GUY'S HOSPITAL GAZETTE [illegible]ST SERIES VOL. 5 1874-75

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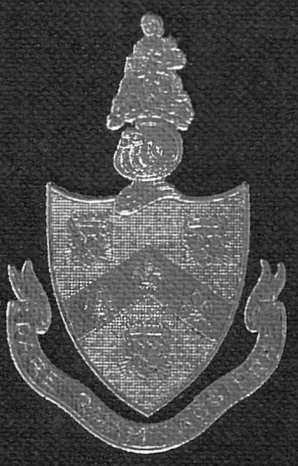

Guy's Hospital Gazette.

Guy's Hospital Gazette.

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GUYS HOSPITAL MEDICAL SCHOOL

Presented by
the Presidents of the Physical Society
March 1878

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Guy's

Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 1. THURSDAY, OCTOBER 1, 1874. TWOPENCE

GUY'S HOSPITAL LIBRARY

IN last week's *Gazette* a short notice informed its readers that a change in the editorship would occur. The superintendence of the *Gazette* was, greatly to its detriment, frequently changing hands, and the practical difficulty of continuing a journal brought out by students, whose term at the hospital was necessarily so uncertain, has at length become insuperable.

Some time back it was suggested that the Presidents of the Physical Society should become editors of the *Gazette*, if a favourable opportunity offered; but it was only last week that, at a general and well-attended meeting, the Presidents decided to undertake the duties of Editorship.

If the *Gazette* is to be continued at all, it will clearly be carried on to better advantage by a perpetual society than by one or more ever-changing individuals.

The advisability of reducing its present weekly issue to that of a fortnightly publication was fully entertained; but it was thought, on the whole, that the interest of the journal—especially to those of its readers living in the country—mainly depended upon its hospital news, the freshness of which would, in a fortnightly issue, be to a great extent lost.

We have the advantage of an opening session with which to commence our endeavours; in a few days we shall hope to see the museums and lecture-rooms teeming with new faces not less in number than we have been accustomed to see on previous years.

With regard to the question of subscriptions we shall, we are sure, be pardoned for impressing upon our readers the absolute necessity for payment in advance, without which we fear we shall be quite unable to proceed.

We think also that we are justly entitled to look for a little further support from our readers, especially from those who have left the hospital and are scattered all over the country. If they would only inform us of any interesting case or circumstance which falls under their notice, we should have a varying and never-failing fund of reliable matter, collected from innumerable sources.

Our expectations with regard to the *Gazette* were not, we think, great, but nevertheless the present realization of them has fallen somewhat short; this is certainly due to the deficient organization depending upon the short time that we have had at our disposal to collect and arrange the matter for this number, which it was thought advisable to bring out on the 1st of October, instead of publishing it on the usual day, which would have been two days later.

We had intended, chiefly, to give a fuller account of the hospital news, and with that purpose to have had a weekly record of the proceedings in the Surgery, Post-Mortem Room, Operating Theatre, Eye Wards, &c.; notes from several of these have appeared in this number, and in the next issue we hope to have each of them fully reported.

We had proposed to give a report of the recent case of hydrophobia which had occurred in the hospital, but this will probably appear at a future time in one of our medical contemporaries.

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Reports of Cases.

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CASE OF FATAL ACCIDENTAL HÆMORRHAGE.

On August 25th, the Junior in Charity was summoned at 2 a.m., by an extern, to a case of hæmorrhage before the birth of the child. On arriving at the case he found the woman very pale and collapsed, somewhat restless, and with a pulse of 140. The os uteri was dilated to the size of half a crown, and the membranes were unruptured; there was no placenta to be felt. It appeared that the hæmorrhage had come on before labour, while the woman was standing talking to a neighbour; about two days previously she had strained herself in lifting a heavy tub, but this was followed by no hæmorrhage at the time.

Under these circumstances the membranes were at once ruptured, and after a short time a dose of ergot was given; neither of these measures, however, brought on any pains, and accordingly the Senior was requested to see the case, the pulse having now risen to 150-160. After he had done so, Dr. Galabin was communicated with, and he at once came down. By this time the condition of the woman had become still worse, the restlessness being very great. It was considered advisable to deliver her without delay, and turning was decided upon in preference to forceps, the os being not larger than a crown-piece. Chloroform was given during the operation, which was effected without difficulty; the child was still-born. As the uterus did not contract at once after the removal of the placenta, some perchloride of iron was injected without delay, for it appeared that a very slight additional loss of blood would kill the patient. Notwithstanding this prompt arrest of the hæmorrhage, however in a few minutes the state of the woman became alarmingly worse; brandy and opium were given freely, a considerable quantity of the former having been already administered during the progress of the labour. She was placed in bed with the pelvis and legs raised and the head low; but it was quite impossible to keep her in this position, owing to her uncontrollable restlessness. Great thirst and a feeling of suffocation were also prominent symptoms, and she repeatedly asked that the windows should be opened.

Transfusion was now determined on, but before the apparatus could be procured from the hospital, the death of the patient took place, some six hours after the time that she was first seen.

A CASE OF POST-PARTUM HÆMORRHAGE.—INJECTION OF PERCHLORIDE OF IRON.

Reported by Mr. F. Blaker.

On June 22, at 2·30 p.m., the writer was called to attend M. A. I., in her third confinement. A pale sallow woman, but fairly nourished. Membranes had ruptured, and about a quart of liquor amnii escaped. This was six weeks before full time. No pains. Os uteri out of reach.

On June 23, at 6 a.m., was again called. Found her in second stage of labour. Presentation vertex, occipito-posterior. Pains weak and infrequent (once in 15 or 20 minutes.) After about three hours a large well-formed living male child was born, the body being expelled a quarter of an hour after the head. The breech, second position, of a second child now presented. After a quarter of an hour lower extremities were born. The pains were few and weak, and the progress slow, although efforts were made to extract. The child was stillborn. Patient, during the time that means were being used to restore the child, complained of feeling faint and cold. Lips and cheeks became blanched. Pulse 140, scarcely perceptible. Large clots now came away from vagina, followed by gushes of blood. The mattress became saturated, and the blood dropped through on to the floor. Could not remove the placenta, and whilst means were taken to arrest the bleeding, a cab was sent to the hospital for assistance.

On the arrival of Mr. Chicken, the woman presented all the symptoms of severe hæmorhage. Pulse could be felt, but very weak. Brandy had been given before arrival. Attempts were immediately made to extract the placenta, but without success. A teaspoonful of ergot was administered, and the hand passed into the uterus. A single placenta was found adherent to the fundus. Uterus dilated and flabby. Placenta was easily separated and extracted, but neither the presence of the hand inside the uterus, nor external and internal manipulation combined, had the effect of causing contraction of the uterus. A second teaspoonful of ergot was given, but with no effect. By means of a Higginson's syringe cold water was thrown into the uterus, but produced no contraction. The bleeding continued. By steady and continued pressure the uterus could be reduced to a small bulk, but there was immediate dilatation on removing the pressure. A solution of liquor ferri perchlor. fort. (1 in 4) was injected into the uterus. The bleeding immediately ceased, and the uterus being again kneaded to a small size its cavity was emptied of coagula. It remained more contracted but still flabby. A third teaspoonful of ergot was given and ice introduced into uterus and vagina. The uterus was once more kneaded, and a firm pad and binder applied. The woman was extremely exhausted. Pulse 120, very irregular. Brandy was given, and the hæmorrhage not recurring, patient was left.

Three hours afterwards.—Has slept a little. Uterus more contracted. No after pains. Ergot and brandy given. Pulse 112. No hæmorrhage. 2·30 p.m. A few small clots have come away. Has slept for two hours. Feels better. Pulse 100, feeble. Uterus well contracted, binder readjusted. No pain.

June 24.—Slept well all night. Pulse 112. Tongue furred. Clots keep coming away from uterus. No uneasiness. Vagina syringed with permanganate of potash. Diet, gruel and milk.

June 25.—Delirious last night. Clots still come away.

June 26—Bowels open for first time. Lochia plentiful. Still passes small clots. Milk abundant. Skin soft and warm. Tempt. 100·5

June 27—Complains of great heat in lower part of abdomen. Thirst. Rigors. Profuse perspiration. Sometimes delirious. Temperature 100·5. No more clots. Discharge scanty and green, and containing a black sediment.

June 28—Pains in lower limbs. No more rigors. Temp. 100.

June 29—Feels better. Bowels open (second time), Temp. 90·2. Tongue clean; no rigor; no discharge. Omit injection of pot. permang.

June 30—Symptoms unaltered.

July 1—Does not feel so well. Skin hot and dry, tongue furred, bowels confined. Urine loaded with lithates, sp. gr. 1022. No albumen. ℞ quin. disulph, gr. ii. ter die. Ol. Ricini.

July 2—Bowels open.

July 3—Feels better, tongue clean, temp. 98·2, pulse 84. Discharge offensive. ℞ Lot. pot. permang. to be again used.

July 4—℞ Quin. disulph. gr. ii.; tr. ferri. mur. m. 10, tr. aurant. m. 40., aq. ad 1 oz. per diem.

July 6—Better. Temp. 98·8, pulse 84, tongue clean, moist; bowels open.

July 9—Temp. 98·4. Discharge ceased.

July 11—Temp. 92·4, feels well. Milk diet.

July 14—No discharge; gets up daily. ℞ Mist. olei morrhuæ et ferri 1 oz. per diem.

No remarks are necessary to show in this case the value of the injection of the perchloride of iron. All other remedies which usually suffice to ensure contraction had failed, and had it not been for the iron the patient must have sunk, as she was exhausted not only by a protracted labour but also by the subsequent profuse hæmorrhage.

POPLITEAL ANEURISM, CURED BY PRESSURE.

E. H., labourer, and formerly a soldier, æt. 40, was admitted into Luke, under Mr. Cooper Forster, August 18th, 1874, with a pulsating tumour in the left ham. It was tolerably firm, and the pulsations were not very strong; the leg was œdematous, and there was pain down the leg and in the ham. The swelling was attributed to a strain about three weeks ago. Until August 31st no treatment was adopted beyond lying in bed and the occasional application of digital pressure by the patient. At the end of this time the pulsations were, if anything, stronger than before. From August 31st to September 25th the femoral was daily compressed for about six hours by different instruments, the patient managing it himself, with occasional supervisions, except on three days, when he was wholly supervised. Improvement was first noticed on the 19th of September, after which consolidation proceeded rapidly, and no pulsation was felt on the 24th. Tourniquet was discontinued on the 25th, but on account of some recurrence of the palpitation it was reapplied till the 28th, when pulsation had entirely ceased, and the tumour was firm and small.

CO-OPERATIVE DISPENSARIES.

The application of the co-operative principle to the medical attention of the poor has been often discussed and has been partially tried, but never, perhaps, submitted to an experiment so complete as is about to be made in Manchester. An influential body of gentlemen have obtained by subscription a guarantee of expenses for three years' trial. They have enlisted aid from the free hospitals and from the medical profession outside, and it remains to secure the co-operation of those in whose interest the scheme is projected. In a community like that of Manchester there are, of course, thousands of persons too poor to pay doctors' bills on the recognized scale of charges. At the same time the abuses of the medical charities of that city are not unlike those which have been so long acknowledged in London. The problem, therefore, is to afford a substitute which shall place medical and surgical skill of the highest order at the command of the needy on terms that shall be free from reproach, and yet fairly within their means. At present an enormous proportion of the recipients of medical charity are in a position that is worse than pauperism, since it rests on false pretences. They have accustomed themselves to receive in charity what many of them should pay for with ease, and many more with a little effort. If the plan now proposed should be successful, the whole of these unduly dependent classes would become independent shareholders in provident dispensaries. These establishments will be set up in different districts of the city, according to a systematic division. All the poorer inhabitants of a district who are not legally paupers may then attach themselves to its dispensary on payment of the smallest conceivable subscription, which they will pay in health and in sickness alike, but which will entitle them to attendance in sickness without any extra charge. They may choose their attendant for themselves from among the physicians and surgeons who connect themselves with the dispensary, and of whom, it is stated, there will be a considerable number at the outset. The personal independence of the members, as they may be termed, of these dispensaries will be completed by a constitution for their government which will be both representative and elective, as every person paying the stipulated subscription will have a vote at periodical meetings, when the committees of management will be appointed. The district societies will be united, on the federal principle, under a Supreme Council formed of representatives from each of the provident dispensaries, and from such of the free dispensaries as will co-operate in the undertaking. Until the system is in working order this part of it must be incomplete, as at present there are only its promoters and conductors to make a beginning, who will have to wait awhile for the development of the constituency whom they hope to call into being. It is clear that their object may be powerfully served by the promised aid from the free hospitals and dispensaries. The officials of these charitable institutions will furnish daily to those of the provident dispensaries full lists of the names and addresses of applicants for out-door medical attendance. One of the results of the constant interchange of such information will be that the circumstances of all applicants to a charity will be ascertained by the officials of the provident dispensary in their own district, to which they will be referred without scruple on any second application for gratuitous aid when it is believed that they are capable of payment. If their own sense of independence fails to rescue them from their present false position, the hand of help will thus be held out to them with such compulsion as the case requires.

The mischievous state of feeling among the Lancashire poor, which regards medicine, like religion, as a commodity which they have a right to expect will be dispenced gratis by a public functionary, has been ably exposed in the publications of Mr. O'Hanlon, a Manchester merchant. Great difficulty was found, neverthelsss, in drawing up a provident dispensary scheme, which would be satisfactory to the medical practitioners who will have to work it. The arrangement which has been adopted experimentally is that the doctor selected by a member of any dispensary shall be credited with half of all the payments made by his client and his family, the other moiety being retained to meet the expenses of the establishment and the supply of drugs and surgical appliances. For the purposes of the new association, Manchester and Salford have been divided into six districts, in each of which a provident dispensary will be established. One of these will be opened in a few days and buildings or sites have been secured for the others. Working men who believe themselves unable to pay a doctor in the ordinary course, or wish to avoid the burden of occasional heavy bills for medicine and attendance, are called upon with their

families to become subscribers to the dispensary of the district in which they reside, by paying a weekly item of one penny per member. The case of large families in which the rate of subscription frequently repeated might become oppressive is compromised by a provision that the subscription for all children under 13 years of age in any one family is not to exceed two-pence per week. Each enrolled member becomes entitled to receive medical attendance and medicine at the dispensary or at his own home, free of any charge. He retains, as already stated, the privilege of choosing his family doctor from the large list of medical men who have consented to co-operate with the promoters of the provident system. An entrance fee of sixpence for an individual or one shilling for family will be required.

The founders of the Provident Dispensary Association hope that their institutions may eventually become self-supporting, though at first indebted somewhat to the subscriptions of honorary members. But even should the ideal of independence not be so fully attained, the partial help received would be a considerable upward step from the demoralizing reliance upon entirely gratuitous relief.—*The Times.*

The Surgery.

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There have been several interesting cases during the past week.

The scrotum of a child a few months old was seen to be distended on each side of the septum. On one side there was strongly marked translucency; so great, indeed, as to immediately suggest the idea of hydrocele. Reduction was easily accomplished, but each time the tumour returned, the translucency was observed to be less until it disappeared. It was wholly a congenital hernia; no fluid could be detected.

There have been several cases of foreign bodies in the ear. In one case a piece of slate pencil was impacted in the wax near the drum. The ear was syringed with warm water until the pencil fell out. In the case of two children who had peas in their ears accompanied with pain, relief could not be given by this means, as the swelling of the peas so blocked up the meatus as to render the passage of water behind them impossible.

A child a few weeks old was brought with a curious bright red conical projection from the umbilicus. It seemed to be a papilloma, and is gradually disappearing under the application of a solution of nitrate of silver.

There have been several cases of fractured jaw. These are being treated on different principles, the most elegant of which is the intradental wire splint. In some a good position has been maintained by firmly wiring together the adjacent teeth with silver wire, and supporting the jaw with a four-tail bandage.

A new growth from the right testicle was completely concealed by a hydrocele, and it was not until the latter had been tapped that the tumour could be defined. There was no pain on puncturing the tumour but distinct testicular sensation at lower and back part of the mass. Patient is at present in Job ward.

All the acute cases of orchitis and epididymitis have been treated with nitrate of silver, after Mr. Hilton's method, with very satisfactory results. It was noticed that the swelling remaining was greatest in those cases in which treatment had been the longest delayed.

There have been several cases of dog bite. In every case in which it was practicable excision was performed and the wound afterwards cauterised. In some where the lacerations were deep and extensive the bleeding was encouraged and the wound cauterised afterwards.

Ophthalmic Operations.

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The first case was that of an old man, aged 60, from whom Mr. Bader extracted a cataract. No chloroform was given as patient's eye was not too sensitive; the cataract was removed by extraction downwards, the incision being made by a new knife lately introduced by Mr. Bader, the peculiarity of which is that it can be introduced on the nasal side of the cornea instead of on the outer side, thus tending to counteract the natural tendency of the eye to turn inwards.

The next operation, which was performed by the dresser, consisted in removing an eyeball affected with severe glaucoma.

The third was another cataract case, on which a double iridectomy had been previously performed, an incision downwards having first been made, the capsule was removed by forceps and the chalky nucleus easily pressed out. Mr. Bader used the same knife here as in the previous case.

The fourth operation was removal of an eyeball, also performed by the dresser.

The Dissecting-room.

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Everything has here been placed in order preparatory to the commencement of the Session. In addition to the general cleansing, the walls of the Dissecting-room have been re-coloured and the ceiling whitewashed. Students will find in the wash-room a new series of lockers, one of which may be obtained for use by depositing 5s. (to be returned when the key is given up) in the Medical School Office. We notice in the Dissecting-room seven bodies lying ready for dissection, and three others upon which gentlemen are busily engaged, besides several extremities supplied from the operating theatre; yet, owing to the manner in which the bodies have been preserved, there is no odour likely to offend the most sensitive olfactory organ. A new arrangement has been made, by which gentlemen will be able to procure an apron and sleeves of the Injector for 2s. 6d.—a saving of 5s. upon the old charge.

EXTRACTS PROM MEDICAL PAPERS.

Dr. Carruthers, of Edinburgh, reports a successful case of acute tetanus. A boy fourteen years old received some

slight injury, and tetanus supervened. He was treated with hydrate of chloral in ten gr. doses every three hours, in combination with bromide of potassium. On the third day there was marked alleviation of his symptoms, and on the 18th spasms left him, from which time he gradually recovered. Although in sixteen days he had 1,140 gr. of chloral, or 71 grs. a day, these large doses produced no ill effect as long as the spasms lasted, but on their cessation, delusions and other nervous sensations ensued. We may remind our readers that Mr. Burnard, in his paper on "Tetanus," read before the Physical Society, two winters ago, strongly advocated the use of hydrate of chloral, and brought forward upwards of sixteen cases which had recovered through its means in India. Seeing also the success which has attended its exhibition in cases of acute chorea, we may consider the value of hydrate of chloral as a remedial agent as fully established.

A successful case of transfusion is reported from the German Hospital, Dalston. The patient suffered severe loss of blood from an abscess, so it was considered necessary to transfuse. The blood was obtained from the carotid artery of a lamb, and injected into the patient's cephalic vein. Both man and lamb are doing well.

The chief committee in St. Petersburgh of the "Association for rthe Care of Sick and Wounded in War" has decided to admit ladies to practice as army surgeons in the field, and in stationary military depôts. In order that this may be effected, the committee propose to establish courses of instruction for female army surgeons in the medical faculties of all Russian university towns.

M. Sinety, of Paris, has pointed out that the liver is in a fatty condition during lactation, and this differs from the ordinary pathological condition in that the fat appears in the centre of the lobules. From his experiments he is led to believe that the liver fabricates at least part of the fatty matters of milk, aud that the mammary gland directly prodnces the sugar in milk.

Sports.

The following are the Cricket averages of last season :—

Name.	Number of Matches.	Number of complete Innings.	Total runs.	Most in an Innings.	Times not out.	Average.
E. S. Robson ..	3	1	92	65	2	92
G. E. Power ..	5	5	198	120	0	39 3/5
H. Hetley	4	3	106	58	1	35 1/3
W, Gray	6	6	144	68	2	24
J. A. Lewis....	7	9	156	63	2	22 3/7
J. Boughton....	10	9	199	55	1	22 1/9
C. J. Mitchell ..	3	3	38	17	0	12 2/3
A. C. Kendall ..	3	3	30	11	2	10
H. Williams ..	10	12	119	33	0	9 3/4
H. W. Phillips	3	2	18	13	1	9
J. H. Earle	7	6	50	25	1	8 1/3
J. Reader.....	7	4	31	9	4	7 3/4
R. Steele	3	4	22	21	0	5 1/2
H. Liddell	3	4	22	10	0	5 1/2
P. E. Wallis ..	8	9	38	14	0	4 2/9
J. McKern	2	2	6	6	0	3
O. Edwards....	3	3	6	6	0	2
R. Manser	3	3	5	5	0	1 2/3

NEW BOOKS BY MEMBERS OF THE STAFF.

A new edition of Wilks's "Pathology," edited and in great part re-written by Dr. Moxon, is expected to appear in November.

Bryant's "Surgery" has met with a most encouraging sale, both in England and America. In the latter country it was published as a handsome large octavo volume. In England upwards of 3,000 copies have been sold, and a new edition may be expected early next year. This edition will appear in two volumes, and will contain a chapter on Diseases of the Eye.

Dr. Hilton Fagge is engaged in writing a book on Medicine. It will be published by Churchill, and be brought out in the same style as Carpenter's large work on Physiology.

Dr. Pavy's book on "Dietetics" has been most favourably reviewed by the critics. It has had an extensive sale outside the Profession.

The Wards.

MEDICAL.

The following Cases were admitted from Sept. 23 to Sept. 30.

PHILIP.

16—Acute rheumatism—Pericarditis
22—Phthisis
34—Rheumatic fever
38—Abdominal tumour
48—Phthisis
44—Rheumatic fever

ADDISON.

1—Hæmaturia
2—Debility
3—Acute rheumatism
6—Debility
8—Acute rheumatism
11—Phthisis
24—Acute rheumatism
25—Pleuro-pneumonia
29—Dilated aorta—jaundice
32—Facial erysipelas—pericarditis
35—Subacute rheumatism
32—Tonsilitis

STEPHEN.

2—Chronic Phthisis—Albuminuria
8—Acute rheumatism
19—Acute rheumatism
12—English cholera—Spinal curvature—Paraplegia
14—Diabetes mellitus
20—Bronchitis—chronic
22—Acute rheumatism
24—Facial erysipelas
26—Slight paraplegia
27—Pleuro-pneumonia
39—Diarrhœa
41—Facial erysipelas
38—Acute rheumatism
42—Acute rheumatism
46—Rheumatic disease
49—Acute rheumatism

CLINICAL.

18—Ascites—Enlarged liver—Pneumonia—right apex
11—Pneumonia—right apex

MARY.

4—Acute rheumatism
12—Pains in limbs—Lead poisoning
15—Peritonitis—Local obstruction of bowels
17—Acute rheumatism
20—Acute rheumatism

SURGICAL.

The following Cases were admitted from Sept. 23 to Sept. 30.

ACCIDENT.

2—Smashed arm—amputation
24—Sprained ankle

CORNELIUS,

2—Fractured tibia and fibula
6—Compound fracture of internal condyle, radius, and ulna
8—Contusion of thigh
8—Lacerated wound of leg
9—Injury to back
9—Fractured fibula
15—Fractured tibia and fibula
19—Rupture of urethra—extravasation of urine—sloughing of scrotum —perineal section

LYDIA.

21—Mammary glandular tumour, excised
23—Carcinoma mammæ

NAAMAN.

1—Fractured inferior maxilla
2—Strangulated hernia, reduced

LAZARUS.

10—Lacerated wound of leg
13—Stricture of urethra
22—Ununited fractured femur

MARTHA.

13—Submaxillary glandular abscess

JOB.

3—Suppurating Hæmatocele of the tunica, vaginalis opened
14—Lacerated wound of knee
18—Stricture of urethra—cystitis

LUKE.

2—Popliteal aneurism
10—Eczematous ulcers of leg
11—Ulcer after burn
18—Ostitis of lower end of tibia and fibula (?)—bones drilled

DORCAS.

5—Strangulated hernia—operation—sloughing bowel—death
5—Stranguiated heraia—operation
9—Carcinoma mammæ
Cot-Spinal abscess
10—Ruptured urethra
12—Fracture of superior and inferior maxillæ
13—Talipes equino-varus
14—Contusions
15—Fractured ribs—injury to lung (?)
20—Fractured femur

CHARITY.

2—Harelip
8—Tumour of thigh
15—Syplilitic ulcers of leg
18—Syphilitic ulcer of thig h

Correspondence.

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[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

THE READING ROOM.

To the Editors.

Sir,—Some years ago I remember that there used to be attached to the Library of the Hospital a Reading-room. This, I believe, was discontinued on account of the payments so getting into arrears that the subscribed money necessary for furnishing the papers during the coming Session was expended in paying up the old debts.

It was on the present fourth year that, I believe, the debt fell most heavily, but surely sufficient time has elapsed for them to forgive and forget the money for which they got no return. If so, let us take advantage of the opening Session, and renew once more the old order of things; let every man on entering the hospital subscribe 1s., as used to be the case, and provide for themselves and friends that which can now only be found in adjoining public-houses. This arrangemen may seem hard on first year's men, but after years, I think, will show the justice of it, if the money matters be placed in suitable hands. For the favoured few resident in the rooms a Reading-room is not necessary, but to the majority of students it is a great desideratum.

Yours truly,
Pilula Ceruleus.

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VOLUMES II. and III. of "Guy's Hospital Gazette," the latter containing some of the Lectures on Medicine by Dr. Wilks, can be had of the Publisher, price 5s. each. Order at once.

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Guy's Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 2. SATURDAY, OCTOBER 10, 1874. TWOPENCE

IT is impossible, we are sure, for any student to spend the First of October at this hospital, without feeling grateful that Guy's still retains the old custom of beginning the work of the year with an introductory address of welcome, to those who are coming up to be fellow-students.

Apart from the good sterling lessons that are then given us, and the sound advice which is held out for our acceptance, every one must derive an additional stimulus to work, from seeing a host of successful and eminent men assembled together in the place where they have once been students like ourselves. The privilege of hearing such a lecture as ushered in the present Session at this hospital, is not to be thought lightly of, nor passed by as though it were an every-day occurrence. We were pleased, therefore, to see the eagerness with which places were sought after, and we think that the crowd which flocked to hear the lecturer was the highest tribute of respect which the students of this hospital could pay to Sir WILLIAM GULL. A little time ago some lectures on subjects connected with Medicine from the same source were promised us, and we hope that so great a boon to the students will not be much longer deferred. It has been said that knowledge derived from oral instruction is less permanent than if gained by other means, but often the manner and delivery of a lecturer will impress a truth more forcibly on the mind than any book, and it will be recalled as clearly as though the facts narrated had fallen within one's own personal experience. Many things, which will live longer than their hearers, have been said in our theatres and many a man will not easily forget the facts suggested in the introductory address of the present Session.

ON the 1st of October the students and visitors to the hospital assembled in the Anatomical Theatre to hear the opening address by Sir W. GULL, the theatre was found to be far too small to hold the number who wished to be present. DR. STEELE, therefore, arranged that the address should be given at the Bridge House Hotel, whither the students adjourned in such numbers as to cause the quiet housekeepers in the Borough to rush from their houses in amazement. Several small accidents occurred in the stampede, but with these exceptions all passed off quietly.

DR. PYE-SMITH, in his ever-to-be-remembered introductory address, delivered two years ago, insisted on the importance of medical students taking care of their general health by engaging in athletic exercises, and gave the following excellent advice, which all would do well to follow: "There are only two cautions I will give you in this matter. First, while you hold any hospital appointment let nothing interfere with that. You should regard these duties as you will the responsibilities of your future practice, as something which you cannot intentionally neglect without your own self-respect. And next, take up whatever sport you like best, but do not take up more than one."

There are many reasons why football, above all others, should be the sport most adapted for hospital students. In the first place its season exactly corresponds with the long winter Session; commencing on the first week in October it can be played in almost any weather all through the winter, and comes to a close just as men are going up for their First College in April. Cricket, on the con-

trary, can only be played during the short summer session when the attendance of men is not nearly so regular as in the winter, and it has to be abruptly discontinued just when the best weather is coming on. Then, football takes up so very little of a man's time, and time is—or ought to be—a very serious consideration, when the short period of four years is all that most men have to complete their entire medical education. Football is played for one hour only on Saturday afternoon, a time when there is really very little going on at the hospital. There are no lectures then, the dissecting-room is closed, only one physician goes round the wards, and the surgeons, with perhaps one exception, make an effort to keep away on Saturday afternoon. Even the greatly pitied working man takes the Saturday half-holiday, all business men take it, and why should not the hard-worked medical student be allowed one hour in the week to relax his mind and recreate his body. We are no advocates for idleness or dissipation. If men do no work they have no right to claim this indulgence, but the man who sticks to his hospital duties by day and reads steadily every evening, may fairly take Saturday afternoon for football. Unfortunately there are some who idle away all their afternoons, and then, when April comes, and they are unable to meet their examiners, they lay all the blame to football, and vow that they will play no more. But there are, happily, many, on the other hand, who can equally distinguish themselves on the football ground and at the London University, and it is these that really enjoy the game. What can be more enjoyable, after a week's close confinement in lodgings, than to walk down, on a fine Saturday afternoon in October, to Blackheath, and breathe some of its delightful atmosphere? Even some of the overworked members of our Staff would, we are sure, be much benefitted by an occasional visit to the football field, to encourage the game by their presence, even if it would be beneath their dignity to play; if any one of them should feel inclined to take this hint, we would recommend them to make their visit on October 24th, when the best match of the season will take place, viz., Guy's *v.* Blackheath.

Reports of Cases.

EPITHELIOMA OF CERVIX WITH PREGNANCY.

The patient, æt. 41, who is in No. 32, Mary Ward, has had nine children. Pain, fœtid discharge, and hæmorrhage date from fifteen months ago. Patient did not, on admission, believe herself pregnant. The cervix and anterior wall of vagina were infiltrated with the disease. The question arose as to whether tha disease would allow the patient to go to full term, and it was decided that the size of the uterus (not quite up to the umbilicus) indicated about five months gestation, and it was thought Nature might take her course for another two months, when, by the use of Barnes' bags, delivery of a viable child might be effected. The idea of amputation of cervix in the pregnant state was mooted, but the operation, it was decided, would most likely bring on labour, and if not, the resulting cicatrix would almost certainly necessitate craniotomy or Cæsarian section. These questions were set aside next day by the patient miscarrying, the fœtus and placenta being removed without any difficulty. On examination, the fœtus measured 14 inches, and weighed 1½lbs. Brain firm, convolutions appearing, eyelids open, pripillary membrane not ruptured, nails distinct, gall-bladder full—from this it was diagnosed to be from six to seven months, and not as appeared from size of uterus five months.

RETROFLEXION OF UTERUS FROM FIBROID IN POSTERIOR WALL.

This case, No. 36, Mary Ward, is being treated by introducing an elastic ball into the vagina well behind the swelling and distending it with air. By this means the uterus is brought slightly into position.

CASE OF RUPTURED UTERUS.

Reported by Mr. E. Field.

At 10 p.m., on September 25, the obstetric residents were informed by an extern that in a case of transverse presentation the hand of the fœtus was outside the vulva. The extern found this condition of things on his arrival at the case, and lost no time in communicating with the Charity. When the residents, accompanied by Dr. Galabin, reached the house, they found the woman pale, a little restless, pulse small, 120; otherwise there was nothing very noticeable about her condition. The left arm was prolapsed, and the abdomen of the child was posterior. Uterus relaxed; no pains, although there had been some powerful ones a short time before. Tenderness over the abdomen, slight hæmorrhage from vagina. Chloroform having been administered, the Senior turned; there was no difficulty whatever in the operation, and on its completion Dr. Galabin left. Having waited for some time without there being any return of pains, some ergot was given, it being desirable that the uterus should expel the child rather than that extraction should be proceeded with. After waiting some time further without any uterine action having taken place, the woman getting whiter, and the pulse having risen to 140, the child was extracted with very slight traction, still-born. Some hæmorrhage now took place, and the Senior introduced his hand to remove the placenta, when, to the great surprise of all present, the uterus was found to be ruptured anteriorly, and a coil of intestine occupying its cavity. Having removed the placenta, the Junior made an examination, in order that there might be no doubt as to the diagnosis. The woman was much collapsed; brandy and opium were given freely through the night, the pulse being very feeble, 140.

The following notes will show her subsequent condition:—

Sept. 26, 11 a.m.—Some sickness in the night; brandy stopped, ice and milk *ad lib.*, opium continued. Pulse 110, strong. 4 p.m.—Dr. Galabin saw her with the Senior. Pulse 112, temp. 100. 9 p.m.—Pulse 120, temp. 99·5.

Sept. 27, 12 noon—More pains, some retching. Pulse 123, temp. 101·4. 8 p.m.—More sickness, some tympanitis, a good deal of pain. Tongue moist and clean. Morphia suppositories. Pulse 128, temp. 100.

Sept. 28, 12 noon—Hands cold and damp, very restless, still sick; pulse 148, temp. 101·4. 8 p.m.—Hands and feet cold and damp, very restless. tossing about and crying out, no pain, more tympanitis. Pulse very small, somewhat irregular; tongue still clean and moist. Pulse 161, temp. 100·5.

Sept. 29—Died at 5 a.m., eighty hours after the rupture occurred.

The noticeable points in this case are the time the patient lived after the accident had taken place. and the absence of the severe symptoms naturally present at the time of its occurrence, although on looking back now the extern can recognise the moment when the rupture must have happened, as shown by the cessation of the uterine action, and a sudden complaint of abdominal pains about half an hour before the residents arrived at the case.

The following cases of fractured pelvis were admitted in one week, August 12th to 19th :—

No. 17, Cornelius—A railway passenger, fell between the platform and train, when in motion at Charlton Station, but did not get under the wheels.

On admission, the patient was sensible, and could speak. The locality of the injury was not very marked till he was raised to a half sitting posture, when he complained of great pain, and fell back in a state of semi-collapse. It was found that the iliac crests could be approximated considerably on pressure from side to side, great pain being caused and crepitus felt. A catheter passed easily; urine not bloody. Pulse became weak and frequent, and patient died in a state of collapse about an hour after admission. Autopsy showed extensive fracture of the ramus of the pubes on each side.

No 11, Cornelius—Patient was admitted August 15th. He had fallen from the top of an omnibus, impinging on the right side of his body. No injury to thigh; one rib fractured, and yet there was inability to raise the heel from the bed. Pressure on the right iliac crest caused pain, while the anterior superior spine moved towards that of the opposite side, and also moved if pressure were applied from crest of ilium to crest of pubes. There was no crepitus and no fracture of the ramus. The fracture seemed to be partial, extending from between the superior and inferior iliac spine backwards across the innominate bone. There was no difficulty in passing a catheter; urine was not bloody. Patient is now doing well, but still has some pain about the hip. He is allowed to get up.

A. B. came into the surgery August 12th, at 3 a.m. He had been struck on the perinæum by the rebound of a puncheon which had fallen down a shaft out of a crane. An immense wound extended from the right side of the scrotum to the tip of the coccyx, another wound was in the groin. He was very anæmic, pulseless, and had ceased breathing. Hæmorrhage had been very extensive but had ceased. Hand could be buried in the perinæal wound, where extensive fracture of the pubic bones could be felt on each side, while the rectum also was lacerated. The wound in the groin communicated with the other, and the fracture could be felt through it also.

No 18, Cornelius—August 17th, fell under a dray at Norwood, and the wheel passed across his pelvis from left to right, causing considerable contusion over the outer side of his thigh and groin, with subcutaneous effusion of blood. Preternatural mobility of the left iliac bone, fracture of the left horizontal ramus of the pubes distinctly felt, no crepitus. Micturieion normal. He has been resting on his back for six weeks; the blood is absorbed and he has been very comfortable.

A NOTE FOR DRESSERS IN THE SURGERY.

By R. Clement Lucas, B.S., F.R.C.S.

In reading the short report from the Surgery, which appeared in the last number of the *Gazette*, my attention was attracted by the cases in which some foreign body had become impacted in the ear and proved difficult of removal. If I understand correctly the report, neither of the two children brought, each with a pea in its ear, obtained relief from the treatment adopted; and this leads me to suggest a very simple little instrument which, though formerly employed at this hospital, appears to have fallen entirely into disuse.

An ordinary suture-needle, flattened and curved towards the pointed extremity, should be pressed upon a stone or other hard substance so as to turn the point. In this way a minute hook is formed, which is so small that it will pass by any substance however firmly impacted, yet so distinct and sharp that on withdrawal it will catch and exert traction upon any body lying on the concave side of the needle. Armed with this instrument, a dresser will, I think, seldom require to leave a foreign body until the suppurative efforts of Nature may at last expel it from the meatus. I can certainly testify to its employment having often proved successful, when syringing and all the ordinary forceps, scoops, snares, and probes have proved useless. For peas or other spherical bodies it is especially useful, for the hook of the needle catching in the pea causes it to revolve on its horizontal axis, and thus by a rolling motion it is brought to the surface. Sometimes two needles, prepared as I have described, and used in the manner of obstetric forceps, may be found to succeed when one has failed. A forceps framed on this plan with separate blades is sold by Millikin, and appears to be a useful instrument. I do not wish to criticise the treatment employed in the Surgery, but I rather doubt the wisdom of syringing the the ear, when it is clear that the foreign body is a pea—and this for two reasons. First, because owing to the shape of the pea it must, if impacted, almost necessarily so close the meatus as to prevent any fluid from passing by; and secondly, owing to its absorbing nature it will, if not expelled, gradually swell under the treatment, and so render its ultimate extraction more difficult.

If the patient be a child, chloroform is a great aid to the surgeon; and the tiny bull's-eye lamp, invented by Mr. Bader and sold by Weis, is of much service in throwing a strong light into the ear.

THE UNITED GUYITE CLUB.

"In Unitate Robur."

The members of this club, which was formed in 1868, dined together for the sixth time on Thursday, October 1st, at the Bridge House Hotel, when a very pleasant meeting took place. One of the peculiarities of the club is that it has hitherto admitted as members any gentlemen educated at Guy's, irrespective of their year of entrance, provided that they were known to several previously-elected members, and accepted as suitable persons at the general meeting. Advantage was taken of this rule at the meeting held in 1873 to elect a great many gentlemen who formerly belonged to a club established in 1866, but which soon afterwards ceased to exist. Several of those gentlemen were present on the 1st of October, and enjoyed the opportunity of conversing with old friends whom they had not seen for six or eight years. The following gentlemen sat down to dinner:—Messrs F. Carey, Owen Coleman, T. S. Daldy, F. Durham, Elphinstone, R. Holman (Chairman), Monson Hills, C. Jordison, Lidbetter, Clement Lucas, H. Moon, W. Perkins, W. Pinching, Robson, C. Seymour, E. F. Thomas, C. Tice-hurst (Vice-Chairman), Toulmin, W. Wallis. After the usual loyal toasts, the Chairman proposed the "Army, Navy, and Volunteers," which was responded to by Dr. Coleman and Mr. Daldy. Mr. Clement Lucas then proposed "The New Members," for whom Mr. Toulmin replied. Later, Mr. Monson Hills proposed the "Absent Members." and alluded to the much lamented deaths of two—Messrs Edward Earnshaw Cass and Trenerry. The toasts of the evening, "Alma Mater" and "In Unitate Robur," were enthusiastically received, and festivities were continued until a late hour.

In the course of the evening the following gentlemen, the majority of whom belonged formerly to a club established in 1865, were admitted members, and will receive invitations from the Secretary to join the club:—Messrs W. A. Brailey, H. G. Budd, A. Charlton, Collins, O. H. Foster, John Gill, B. C. Gowing, H. Lucas, F. E. Manby, G. T. Muriel, C. Palmer, E. R. Ray, T. Walters, G. Savage.

INGRATITUDE.

One of the most dastardly acts ever recorded of a hospital patient was perpetrated last Wednesday morning by a man who had been for some weeks in the Clinical ward. The patient, a Russian Pole by birth, had received, in consequence of his forlorn condition, a large amount of kindness as well as substantial charity from Sister Clinical, which he rewarded by robbing her of her watch and chain, which she had treasured as an heirloom from childhood. The man contrived to escape from the hospital before the theft was discovered, and there is little probability of his whereabouts being discovered by the police, nor of the restoration of the stolen property. It is often remarked that, although the hospital affords admission to all—and among these to many persons of questionable character and antecedents—yet they have always considered the property of sisters and nurses sacred against their depredations. While deeply sympathizing with Sister Clinical in her loss, which, we trust, may be made good to her in some way, it is a satisfaction to know that the base felony was not committed by an Englishman.

ELECTION OF NEW GOVERNORS.

The vacancies in the list of the Governors of the Hospital, caused by the deaths of Mr. Thomas Baring, M.P., and Mr. Curtis Haywood, were filled up, on Tuesday last, at a Court of Committees of the Governors, when the Right Rev. the Lord Bishop of Winchester and Mr. George Cubitt, M.P., were elected as Governors of the Hospital.

THE NEW ENTRY.

On Wednesday last, 81 gentlemen qualified to register for the first time at the Royal College of Surgeons, had entered their names at Mr. Stocker's Office. Four others had entered for special subjects, making the total of the new entry 85. We understand that the number of students, who have come up to London this month, is smaller than usual.

THE PHYSICAL SOCIETY.

Gentlemen are reminded that the first meeting of this Society will take place this evening, at 7.30, in the Chemical Theatre, when Mr. Edward Cock, Honorary President of the Society and Consulting Surgeon to the Hospital, will take the chair.

Gentlemen in their first year are particularly requested to attend.

Operations.

Friday, October 2.

Mr. Howse amputated a breast for carcinoma. The incision was prolonged towards the axilla in order that an enlarged gland might be removed. There was some difficulty in this. The case was a good illustration of the reason why the incisions for removal of the breast are made in the direction of the fibres of the pectoralis.

Mr. Howse then proceeded to remove a lipoma situated just above the right buttock. It turned out of its capsule easily, and was only slightly lobulated.

A knee-joint was then tapped. Pressure was applied nearly all over the joint by Esmarch's elastic webbing. The fluid flowed slowly from the canrela, and contained a small quantity of pyoid material.

The radical cure for hydrocele by the injection of port wine was performed.

Wednesday, Oct. 7.

Mr. Birkett amputated a breast for carcinoma; the incisions were both convex towards the opposite shoulder and enclosed a half-moon shaped aperture through which the breast was taken out. In this way a long under and short upper flap were formed. After the apparent cessation of hæmorrhage, warm sponges were applied to the wounds to encourage the bleeding, and by this means many more vessels were

discovered. On section the gland was found to be infiltrated with two distinct growths of cancer, one of which seemed more medullary than the other in appearance. After the operation Mr. Birkett remarked how successful an operation was amputation of the breast, he never having in his own practice lost a case.

Ophthalmic Operations.

The session having now begun, the operation-room begins to resume its usual busy appearance.

On Friday, October 2nd, we noticed several distinguished visitors present, among whom was Professor Esmarch, of Kiel. Mr. Bader had four operations, but nothing of very particular interest. The first was a case of cataract, which he extracted downwards, making the incision with a grooved knife. No chloroform was given, and the whole operation was very quickly performed.

In the next case, which was one of cataract in an old woman æt 68, the pupil was very rigid, so Mr. Bader, contrary to the usual practice, performed an iridectomy before extracting the cataract, remarking as he did so that this was rarely necessary in cases of ripe cataract. The other operations were, removal of opaque capsule, and iridotomy or cutting out a portion of iris with scissors, in a case of closed pupil.

On Monday last Mr. Higgens had no less than ten operations, including a squint, two cases of iridectomy, a cataract, which he extracted upwards, operation for entropion, closure of palpebral aperture for ectropion, excision of eyeball, and transplantation of pterygium. This was the second case of pterygium upon which Mr. Higgens has operated during the last few weeks, and as they are not very commonly met with in this country they possess some interest. If these curious growths are excised they are almost certain to grow again, but the operation consists in detaching the apex from the cornea, and uniting it by suture to a wound prepared for it on the conjunctiva below the margin of the cornea, if they are thus transplanted they may grow in their new position without interfering with sight. Both of Mr. Higgens's cases occurred in sailors, and he remarked that nearly all patients with pterygium in this country were sailors, many of whom had been in the East.

The Dissecting-room.

The Dissecting-room has seldom presented so busy an appearance, even in the middle of a session, as it does now, with fourteen bodies undergoing dissection. We are glad to see that owing to the plentiful supply of bodies, four subjects have been allotted to first year's men, and there will be probably no complaints at the end of this session that certain gentlemen have only been able to procure one part each during the winter. The chief cause of the delay in procuring 'parts' last year, was owing to the persistence with which gentlemen in their first year retained their names on the lists for 'Uppers' and 'Lowers,' when for the other parts there were no applicants. This difficulty has now been overcome by the Demonstrators having refused to first year's men the choice of parts. A single list only is posted, upon which the names of gentlemen wishing to dissect are placed, in the order of their application at the Medical Office. From this list eight names are taken whenever a body comes into the room, the two first on the list receiving 'Heads' and the last two 'Lowers.' No restriction has been placed upon second year's men, who put down their names, as formerly, for the part they desire to dissect.

Mr. Lucas has commenced his classes for those gentlemen who intend to present themselves for the November Examination at the College, but few seem desirous of going up in the "unlucky month."

The Surgery.

Several cases of phymosis in children have occurred lately; these have, with one exception, all been treated by simply slitting up the prepuce. The treatment was very satisfactory except in one instance where the divided foreskin did not retract but became hard and lumpy. The child was afterwards circumcised and is doing well. In the case where slitting up was not done, circumcision was at once adopted, on account of the mucous membrane of the prepuce being adherent to the glans almost to the edge of the urethra.

Of three cases of dislocation of the humerus in adults, two were reduced by very little force. The first by manipulation, extension and adduction; the second by the leverage of the heel in the axilla. In the third chloroform was given as there was considerable resistance on the part of the patient.

A man, who had fallen on his hand, was brought with a peculiar deformity at the wrist-joint. The carpus was thrown on to the dorsal surface of the ulna, the end of which formed a marked prominence on the anterior aspect. The end of the radius, however, could not be felt. On reducing the dislocation this bone was found to be fractured immediately above the styloid process. Chloroform was given, but a good position could not be secured.

In a case of hydrocele, the testicle occupied the front and upper part of the sac. There was no doubt as to the nature of the tumour, and the position of the testis was ascertained before tapping, otherwise, if the operation had been performed in the usual manner and place, the gland would certainly have been punctured.

As many questions have been asked as to the way of applying nitrate of silver for orchitis, the following instructions may be useful:—Let the scrotum be well washed with soap and water, and when dry a solution of caustic—two drachms to an ounce of distilled water—is taken and painted over the scrotum on the side of the affected testicle. The pain is sharp but soon passes off. The patient must rest, as exercise will seriouslyi nterfere with the remedy. The application is equally efficacious whether the inflammation be gonorrhœal or idiopathic.

Statistics for September, 1874.

The following cases were treated in the Surgery during the month.—

Male.		Gonnorrhœa	3
General Injuries—		Ganglionic tumour	2
Upper extremity	108	Paraphymosis	9
Lower ditto	95	Erysipelas	2
Trunk	60	Syphilis	4
Head and face	77	Varicocele	1
Fractures—		Erythema	1
Jaw	2	Neuralgia	1
Clavicle	7	Ulcers	2
Acromion	1	Prostatitis	1
Humerus	1	Female.	
Radius and ulna, compd.	1	General Injuries—	
Radius	8	Upper extremity	51
Ulna	2	Lower	28
Metacarpal bones	1	Trunk	23
Ribs	20	Head and face	43
Metatarsal bones	1	Fractures—	
Dislocations—		Humerus	2
Acromial end of clavicle	4	Radius and ulna	1
Humerus	2	Radius	5
Radius & ulna backwards		Ribs	0
Carpus	2	Jaw	1
Do. backwards, with fracture of radius	1	Clavicle	9
Thumb	1	Metacarpal	2
Little finger	1	Dislocations—	
General—		Humerus	2
Crushed fingers	25	General—	
Wounds of hand	67	Phymosis	2
Divided radial artery	1	Hydrocele	3
Ulnar	2	Hernia	5
Wound of eye	2	Inflammation of gland	2
Rupture of eyeball	1	Retention of urine	3
Bite of animals	9	Burn	4
Stab in mouth	1	Scalds	6
Needle in arm	1	Wound of hand	25
Ditto thumb	1	Disease of hip	1
Fish hook in lip	1	Foreign body in throat	5
Rupture of plantaris	1	Do. in eye	1
Concussion	2	Do. in ear	3
Synovitis	8	Do. in hand	1
Hydrocele	3	Abscess	11
Teeth extracted	146	Tongue-tied	5
Scalds	10	Disease of knee	5
Burns by fire	4	Ulcers	3
Do. sulphuric acid	1	Crushed fingers	4
Wound of tongue	1	Tumour in eyelid	1
Aural catarrh	1	Phlebitis	1
Scabies	2	Ophthalmia	1
Diarrhœa	56	Genu valgus	1
Hæmoptysis	1	Bite of animals	3
Cephalalgia	2	Necrosis	1
Paralysis	2	Papilloma	1
Poisoning mussels	1	Ganglionic tumour	2
Do., turpentine	1	Poisoning by paraffin	1
Epistaxis	1	Do. by fish	1
Sore throat	5	Bursitis	1
Eczema	1	Tonsilitis	1
Foreign body in eye	8	Vulvitis	1
Do. in Ear	2	Subcutaneous tumour in scrotum	1
Eclampsia	1	Prolapsus ani	1
Stricture	6	Sore throat	3
Bone in throat	3	Disease of skin	7
Orchitis	5	Diarrhœa	32
Sebaceous tumour in scrotum	1	Dyspepsia	5
Abscess	1	Hysteria	
		Teeth extracted	154

Sports.

ANNUAL MEETING OF THE FOOTBALL CLUB.

The usual October meeting was held on Tuesday, October 6th, when about 30 members were present. Mr. Gibb was in the chair. The Captain and Secretary being absent the accounts could not be read, but they are, we learn, in a satisfactory condition, there being a small balance in hand. Seventeen matches have been arranged to take place during the present season for the "I. Fifteen," and twenty-two for the "II. Fifteen."

Mr. Smart proposed, and Mr. Wells seconded, that Messrs. Pinching and Gilbert be re-elected Captain and Secretary respectively, for the ensuing year. This was carried unanimously.

The Blackheath Dressing-room is at the "Princess of Wales" hotel, situated close to the heath.

The jerseys are the same as last year, blue and orange. The Chairman impressed upon the members the necessity of each providing himself with one as soon as possible.

Mr. Gibb proposed that the Committee should collect the subscriptions. This was carried.

The meeting then terminated, after a vote of thanks to the Chairman.

To-day the Guy's Football Club will commence the season by an opening game, in which the first fifteen will be pitted against all comers. It may be interesting to our readers, and especially to first year's men who are about to join the club, if we publish the following list of matches played by the first fifteen last season, with their results;—

Against whom.	Results.
Oct. 11.—Opening Match	
18.—St. George's Hospital	Won. 1 goal, &c.
25.—St. Thomas's Hospital	No Match
Nov. 1.—Arab F.C.	Won. 2 goals, &c.
8.—University College Hospital	Drawn in favor of Guy's
15.—St. Mary's Hospital	Drawn much in favor of Guy's
22.—London Hospital	Won. 1 goal, &c.
29.—Clapham Rovers	Won. 3 goals, &c.
Dec. 6.—King's College Hospital	Won. 2 goals, &c.
13.—Blackheath F.C.	Lost. 1 goal
20.—Richmond F.C.	Lost. 2 goals
Jan. 10.—Blackheath F.C.	Drawn
17.—London Hospital	Won. 4 goals, &c.
24.—St. George's Hospital	Won, 2 goals, &c.
31.—St. Mary's Hospital	Won. 3 goals, &c.
Feb. 7.—St. Thomas's Hospital	Drawn in favor of Guy's
14.—University College Hospital	,, ,, ,,
21.—King's College Hospital	Won. 7 goals, &c.
28.—Clapham Rovers	Drawn much in favor of Guy's

Matches Played.	Won.	Lost.	Drawn.
17	9	2	6

We understand that the Secretary has arranged some good matches for the ensuing season, and if there should be any talent at all among the first year's men, Guy's ought to turn out an invincible team, as we believe nearly all the last year's players will play again.

The Wards.

MEDICAL.

The following Cases were admitted between Oct. 1 and Oct. 7.

MIRIAM.

20—Purpura. 24—Enterica. Cot.—Scarlatinal dropsy. 30—Aortic aneurism.

JOHN.

1—Malignant disease of œsophagus. 8—Malaria: 11—Glossitis,

MARY.

6—Chlorosis. 14—Phthisis. 17—Acute rheumatism. 20—Acute rheumatism, pericarditis, pleuritis. 21—Snbacute rheumatism.

PHILIP.

14—Acute rheumatism. 22—Epilepsy. 24—Subacute rheumatism. 36—Erythema marginatum. 39—Ascites, corrhosis of liver.

STEPHEN.

7—Diarrhœa, tubercular (?). 12—Acute rheumatism.

ADDISON.

14—Facial erysipelas

SURGICAL.

The following Cases were admitted between Oct. 1 and Oct. 7.

ACCIDENT.

1—Fracture of the neck of the femur. 3—Fracture of tibia and fibula. 8—Pott's fracture. 13—Fractured pelvis (?) 15—Fractured tibia and fibula. 23—Contusion of abdomen. 24—Strangulated hernia, reduced by taxis. 24—Abscess in abdominal walls. 30—Crushed toes, amputation.

CORNELIUS.

8—Foreign body in ear.

LYDIA.

10—Tumour in perinæum. 22—Necrosis of inferior maxilla.

MARTHA.

2—Talipes calcaneo, valgus. 4—Tumour in the frontal region. 8—Carcinoma mammæ. 9—Morbus coxæ. 14—Harelip, operation. 18½—Necrosis of tibia. 20—Carcinoma mammæ. 22—Excised fracture.

LAZARUS.

7—Acute synovitis in knee-joint. 11—Malignant tumour in neck. 11—Concussion, scalp wound. 15—Hydrocele, radical cure.

NAAMAN.

11—Synovitis, knee and ankle. 15—Eczema.

LUKE.

9—Stone in bladder.

JOB.

4—Necrosis of tarsus. 10—Stricture of urethra. 15—Morbus coxæ.

DORCAS.

1—Necrosis of carpus.

CHARITY.

5—Painful stump. 21—Necrosis of ulna.

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VOL. V.—NO. 3. SATURDAY, OCTOBER 17, 1874. TWOPENCE

BY permission of DR. HICKS we are enabled, in the ensuing numbers of the *Gazette*, to publish notes taken from the lectures on midwifery given during the past Session. As Dr. HICKS has kindly promised to revise them as they pass through the press, it will be unnecessary for us to dwell on the immense advantage they will be to the students of the hospital. We would also take this opportunity of thanking those members of the staff, who do us so great a benefit as to read through the notes of their clinical lectures, &c., before they are given to the printer. We are sure this will be appreciated by our readers, for it converts casual notes into a perfectly trustworthy account of the subjects of which they treat.

Clinical Lectures.

—o—

ON "SORE THROAT."

By S. O. HABERSHON, M.D.

(Being a portion of the Clinical Lecture delivered October 10th, 1874.)

There are few maladies you will be called upon to treat more frequently than "sore throat." In the Clinical ward at the present time, we have an instance of a man affected with an ordinary sore throat, from exposure to cold, and you will find this condition one of very frequent occurrence, especially during this time of the year. The throat is affected with different degrees and different forms of inflammation. Perhaps the simplest kind is what we may call inflammatory congestion, a state of simple catarrh. In such a case you examine the throat and you find the tonsils, uvula, and pharynx, red, and injected. There may be februle disturbance, the pulse quickened, and the temperature somewhat raised. Then the patient complains of dryness and a little pain, and soreness about the throat. In many instances the pain passes up towards the ear in the direction of the eustachian tube, owing to the extension of the inflammation in that direction. If the mischief extend downwards into the larynx, you find they have hoarsness, because the catarrhal state affects the vocal cords, their vibration is interfered with, and the voice becomes altered; it may be even lost. What is the best thing to do in these cases? Some are very partial to the application of nitrate of silver. This is a very favourite mode of treating sore throat, and in some cases it certainly appears to produce a marked effect. I think, however, you will generally find greater relief afforded by soothing the throat. Apply warm fomentations externally, and let the patient inhale steam. This is better than using ice, because ice only relieves for a very short space of time, there is greater reaction, and the disease does not subside so quickly as if you had employed warm remedies. You may gargle the throat with warm water, or chlorate of patash, in infusion of roses, at the same time apply a poultice externally, or—a favourite remedy now—the wet compress. If you give any medicine internally—which is not necessary—let it be some simple saline diaphoretic, as acetate of amonia, efferescing mixture, or citrate of potash. Act pretty freely on the bowels with seidlitz powders or saline purgatives. As to diet, let it be only of a bland simple character, as arrowroot, and articles of that kind. This is the ordinary catarrh of the throat, but the case at present in Clinical Ward is more severe. It was produced in the same manner the ordinary sore throat is produced, but after going on for several days the patient was unable to swallow. When admitted into the hospital we found considerable œdema of the pharynx and the uvula, also in a œdematous state, appeared to be adherent to the left palatine arch, and there was a dusky red about the whole mucous membrane. This form of inflammation closely resembles what we usually speak of as 'erysipelatous.' It is that kind of inflammation you find coming on after exposure to cold or wet, in persons who are in an enfeebled

and bad state of health, there is œdema, and a dusky redness, appearances which would lead you to suppose that part of the mucous membrane was about to slough. In this case there was a good deal of swelling about the posterior pillars of the fauces, not so much about the anterior pillars and the tonsils, and we were very doubtful whether there was any local suppuration. The patient himself thinks that "something gave way," and the microscope is said to have given evidence of pus cells. It is, however, difficult to distinguish the muco-purulent discharge of the mucus membrane from true pus. In these cases of "erysipelatous inflammation of the throat"—if I may use the term—you find the patient is exhausted. There may be very little elevation of temperature, but the pulse is compressible, and if you observe the treatment we adopted, you notice we felt he required nourishment. Strong beef-tea and port wine are, I think, the best remedies in these cases. If you find the difficulty of swallowing is very great, you may administer a nutrient injection—a wine glass full of beef-tea, an egg, a spoonful of brandy, and a few drops of laudanum. Encourage your patient to swallow; although the first attempt is very painful, the second and third will be less so. In these cases of œdematous sore throat you will generally find very little good from the application of caustic. I think you will commonly do more harm than good. In some of these cases you will find it very useful to employ astringents, and the remedy I generally use is gallic or tannic acid, you may mix this with honey and infusion of roses, or you may order a gargle of alum. Apply warmth externally, and you generally find the patient quickly relieved.

(*To be concluded in our next.*)

ON A CASE OF STRANGULATED HERNIA.

By J. Cooper Forster, M.B. Lond., F.R.C.S.

Surgeon to, and Lecturer on Surgery at, the Hospital.

Mr. Forster began his lecture by stating that a patient had just been admitted into the hospital, who for the last ten years had noticed a swelling in the groin, which had not caused him any trouble until six days ago, when he was taken with a pain across his stomach and constipation. On the following days nausea set in and vomiting, these had continued until admission. There was felt to be a firm nodulated tense swelling in the left groin, lying over Poupart's ligament. It must be remembered that in these cases the patient does not come to us and complain that he is suffering from a strangulated hernia, but says he feels sick, that his bowels are confined, and that he has a pain in his stomach. We are apt to overlook the existence of a hernia, as these symptoms may be accounted for by other and more common causes, such as a temporary derangement of the stomach, caused by irregularity of life or excess of drink. Naturally we feel inclined to administer an aperient in these cases, but to do so is a grievous error, it is the first error in the treatment, and it is the worst. Whenever a patient comes to us complaining of the above symptoms—sickness and pain in the abdomen, &c.—our first question ought to be: Is there any swelling? This will usually be denied, especially in the case of women, who, even when conscious of a tumour existing, will deny the fact in order to escape examination. Frequently patients will ask for an aperient, and thus lead the medical man into an error he would not otherwise have committed. At a hospital our cases are ready diagnosed for us by the dresser, to whom the credit is due, but in private practice it is not so, and in such cases we should always place our hands on the groin to see if there be a swelling or not. Of course every case of constipation need not be examined, but it is better in this respect to err in commission rather than omission. If, then, a patient comes to us with the before-mentioned symptoms, and we find him suffering from a swelling in the groin, we must carefully examine it. Firstly, as to its being a hernia; secondly, whether it is old or recent, and if so, thirdly, whether it be inguinal or femoral. Strangulation may occur in two ways, a piece of intestine may suddenly descend, become strangulated where nothing has previously existed, or, in the case of an old hernia, sudden acute symptoms may be caused by the nipping of a small knuckle of intestine underneath a piece of omentum. In these latter cases the prognosis is more favourable than where the bowel has come down for the first time and become strangulated. What, then, is the best thing to do? We must remember the "groin" consists of that lower part of the abdomen and the upper part of the thigh which comprise the inguinal and femoral regions. An inguinal hernia is more formidable in appearance than a femoral. A femoral hernia is smaller, and the symptoms are more acute than the inguinal. In the present case the hernia is femoral, and the patient, to relieve his constipation, has taken aperients and refused to submit to an operation which was suggested to him before his admission into the hospital. Now, never give aperients where you find a hernia with sickness and constipation existing together. What plan must then be pursued. If a hernia be seen immediately after strangulation, attempts may be made to reduce it at once; if this be impossible, give a hot bath and a full dose of opium, and in four or five hours try the taxis again; if reduction cannot be now effected, immediately give chloroform and again try the taxis. If the bowel cannot now be put back an operation should at once be performed. The operation, if performed early, is one of the simplest in surgery, but it must be done at once. It is delay that is dangerous. Be prompt. Patients suffering from strangulation may have very few symptoms, sometimes not even constipation, but this is deceptive. The motions are simply caused by the lower bowel—the intestine below the seat of stricture emptying itself. This often gives rise to temporising, and the patient is said to be better, but he cannot be better until the strangulation is relieved. On the patient being brought into the theatre Mr. Foster remarked on the characters of the swelling, and asked, how do we know that this is a femoral hernia? We know it from the following characteristic conditions:—The testicle is free and the scrotmm not implicated. The finger can be placed on the spine of the pubes and the tumour felt to the outer side. This would not be the case if the hernia were inguinal, for then the swelling would be on the inner side. The redness of the swelling might be due to inflammation caused by attempts at reduction, or by the icebag which had been applied during the short time he had stayed in the ward. There was irregularity of surface on feeling it, and this might be caused by the presence of omentum in the sac. This was probable, because often in old cases of epiplocele symptoms of strangulation occurred suddenly, owing to the omentum having led the way, as it were, for a portion of bowel which descended, and was retained. In the present instance it was probable that only a very small knuckle of intestine was involved, perhaps not larger than half a phalangeal joint, because the symptoms had not been very severe. On the

other hand, when the whole calibre of the bowel is implicated, the symptoms are usually much more urgent. But, in the present case, because of the mildness of the symptoms, there was no cause for delay; for often when but a small surface of bowel is concerned there will be apparently few symptoms during the whole course of the strangulation. The patient being now under the influence of chloroform, Mr. Forster proceeded to operate. The skin was cut through and a large gland was exposed, which caused the marked prominence on the swelling: the gland was turned aside, and on making another incision the sac was exposed; a hernia director was passed under the seat of stricture and Gimbernat's ligament slightly divided; taxis was now applied to the sac, and the bowel returned leaving a small portion of omentum adherent to the sac, which was thick. After the wound had been lightly dressed with lint, Mr. Forster said that in a case of hernia where twenty-four hours had not elapsed since the descent of the bowel, it was warrantable to apply any amount of force, but if more than a day had elapsed this was not justifiable, in fact the less taxis then the better. Taxis failing, an operation must be performed or the patient will surely die, not more than one in a hundred of those who refuse to undergo the operation surviving with an artificial anus. With regard to the dressing, Mr. Forster has a great objection to the use in these cases of a pad of lint and a spica bandage, as by that method the wound is so covered up as to render it a matter of difficulty for the surgeon to tell what progress was being made. It was preferable to have no dressing at all. It was not well, however, that the patient and his friends should see the large wound, hence it was customary for him to use a small piece of lint only, as by this means the wound is readily seen, and there is an easy escape for serum or pus After the operation the sickness of the patient might continue, but the cause now would be the chloroform. To-morrow the pain in the abdomen would be gone, and he will feel more comfortable. The wound caused by the operation does not heal quickly, three or four weeks generally elapsing before the patient is well. Of three cases, however, which were operated on in one week, one healed by primary union, a truss was applied at the end of a week, and in two weeks the patient left the hospital well. Care must be taken not to overfeed the patient. The wound may be extensive, and a good deal of repair necessary, but a low diet will suffice to complete the process. Fish may be given after a few days, but meat should be avoided until there has been an evacuation of the bowels. When the bowels have been long confined the patient may have a motion shortly after the division of the stricture, but it is better for the bowels to be undisturbed for a week or two, for they will generally relieve themselves after the injury has been repaired. In a case under the care of Mr. Birkett, three weeks elapsed after the operation before there was an evacuation of the bowels. Mr. Forster recalled the time, when a student himself, he remembered to have seen white mixtnre given after an operation for hernia; whereas now the opposite is the practice, and opium is administered, while aperients are forbidden however long the bowels may be before they act, unless the patient begins to suffer constitutionally, when an enema will usually relieve the symptoms at once.

Evelina Hospital.—Mr. Miles has been appointed Clinical Assistant to this hospital.

In accordance with the last wish of the late Lady Dilke, her husband, Sir Charles Dilke, has removed her body to Dresden for the purpose of cremation.—*Sanitary Record.*

Physical Society.

—o—

The first meeting of this Society during the present Session was held on Saturday, October 10th, Mr. Cock, Honorary President, being in the chair. The minutes of the previous meeting having been read and confirmed,

Mr. Cock rose and said:—I must thank you warmly for the hearty greeting you have given me, and most cordially welcome the new men at the commencement of another session. I see several old faces around me, and many which are not familiar, and which I therefore take to be new—I will not say raw—recruits, and I look with more interest on these recruits than upon the old men, because I can speculate upon them, and I can only hope they will imitate the example of many who who have already left these walls. I have seen, during the last thirty-five years, several thousand students pass through the theatre into the busy scenes of life, and I have seen and heard of many having become illustrious, and therefore men who have done honour to their education at Guy's. It is, I think, one of the glories of this school that, within my memory—which extends very far back—the Governors of this hospital have never had occasion to go beyond its walls to find successors as regards appointments, when a vacancy has occurred. All the officers elected within my memory—and I tnink it will extend beyond me—have been reared within Guy's Hospital. In speaking of the Physical Society, I am reminded of another institution, which is of later growth, I mean the *Guy's Hospital Gazette.* Nothing ever gave me more pleasure than to see the *Gazette* when it was started, and all praise and honour to those students who first undertook such a useful and excellent publication. Both the Physical Society and the *Guy's Hospital Gazette* are essentially students' institutions. I see that journal every week, I read it, and, if I do not find anything particularly new, I always find something that sets me thinking. It gives one a great advantage to be able to see at a glance all the cases that have been admitted into the hospital during the week, so that a student who is investigating a particular form of disease can find at one glance where to seek for patients who may enlighten him upon the subject in which he takes at that time particular interest. The only thing that I was afraid of was that it might not last. It was taken up first by men of intelligence and talent, and it was well done, but I could not help thinking it might prove transitory. That those who spent their time on it could not stay here, and that they might transfer it to others who might not be so efficient and could not have had the experience they had. I was, however, last week, very much delighted to find that all danger of this had been averted, as the Presidents of this Society had taken the journal into their own hands. Therefore there can be no fear for the future, and there can he no doubt that it will be conducted in the most efficient manner it possibly can be.

The Chairman then called upon Mr. Lancaster to read his paper on "Turning as a means of delivery," of which the following is an abstract;—

Mr. Lancaster began his paper by giving a definition of Turning, and a sketch of its history. Version might be spontaneous or artificial. The former was rarely seen, its mode of production and conditions necessary were glanced at, a case being given in illustration, Artificial turning may be Cephalic or Podalic. It might be done either by acting on the two poles of the fœtus by both hands or by introducing one hand into the uterus, and

so bringing down the part we wish. Cephalic version was not applicable to those cases that required rapid delivery, as by it alone the child could not be extracted. It was indicated when the fœtus was placed rather obliquely and in some cases of shoulder presentation. The modes of operating were then looked at—1. By posture. 2. By external manipulation. 3. By combined external and internal manipulation or Dr. Hicks' method. 4. By passing a hand inside. He then took Podalic version. This could be used to convert an abnormal presentation into a more suitable one, and also to hasten extraction. It was required in Transverse Fresentations, in cases where labour must be hurried, in face presentations where face will not enter brim or forehead comes down anteriorly, in funis presentations, .n some cases of ruptured uterus, of sudden maternal death, of pelvic obstruction, and also to facilitate premature labour, in moderate contraction of pelvis, thus obviating craniotomy. He then touched upon the question of chloroform, and thought it should be given not only in the old way of operating, but also in most cases in which Dr. Hicks' method was used, although objections had been raised. With regard to position of patient, the left lateral was by far the best usually. That on the back was used chiefly in abdomino-anterior positions of child. The knee-elbow position was objectionable. He showed that it was often advantageous to bring down a knee instead of a foot, the furthest off one being best, and the several objections to bringing down both feet were brought forward. As to the hand employed —the advantages of the left in most cases were pointed out, although the Germans use different hands according to the position of the child. The difficulties that might be met with in both methods were stated, many might be obviated by chloroform. A case in illustration of some was given. He then enumerated dangers of the ordinary mode, viz., shock, and more or less injury to the uterus, &c., or after inflammation. To the child the dangers lie in extraction, not in turning, compression of funis being chief, but joints may be dislocated, or brain injured by compression There was hardly any danger in the combined external and internal operation. The advantages of the latter method were then shown, version could be performed early, which in placenta prævia was of importance. The above dangers were avoided, and in cases of convulsions there was less peripheral irritation, &c. But there were still some cases in which the old method would have to be done. He thought the combined external and internal possessed advantages when it could be done, and in many cases the difficulties were not insuperable. In most cases it should be tried, because if it failed it did not prevent the other mode being done afterwards.

In the discussion that followed,

Mr. Clarke, while admitting the importance of the operation, thought that the paper had not materially increased their knowledge on the subject, or added any new facts which could not already be found in the ordinary text-books.

Mr. Vinter remarked, that sometimes great difficulty was experienced in getting the head through after turning. In such cases Dr. Hicks had said that it was better at once to use forceps. He thought it bad to administer chloroform, on account of its ill effects upon the child. If the os were very rigid what would be the treatment? He suggested bleeding the woman to fainting.

Mr. Jones thought the paper a very able one, and that Mr. Lancaster deserved great credit for his boldness in coming before them on the first evening of the session at a very short notice.

Mr. Rees was in hopes that Mr. Lancaster would have gone into the various causes of mal-presentation of the fœtus. He thought chloroform was apt to occasion sickness, and advised chloral hydrate instead.

Mr. Fry thought that in some cases of sudden maternal death, turning would be preferable to Cæsarian section as being less objectionable to the friends. With regard to version in cases of convulsions, he described a case admitted into the hospital last week, where the membranes were punctured, the albumen—partly present—disappeared the next morning, and in the evening the patient miscarried without any more serious measure being necessary. In cases of convulsions, therefore, with normal presentation he would puncture the membranes first.

Mr. Shadwell referred to a case reported in the *Gazette* for last week, where, after turning had been performed, it was discovered a rupture had previously existed. In that case turning ceased to be the correct practice. He denied that chloroform would have much effect upon the fœtus, and preferred it to chloral hydrate.

Mr. Waterhouse preferred the old method of turning to the new, as all the difficulties of the former were present in the latter, and the new had the disadvantage that it took longer in performance. He would not attempt to turn after the membranes had been ruptured long.

Mr. McCarthy described a case of turning in which he had seen chloral hydrate administered.

Mr. Reynolds thought that Mr. Lancaster had lost sight of the antagonistical conditions of turning. He advised the administration of chloroform.

Mr. Routh advised them to bring down both legs, as there would be more to hold by to extract with, and less chance of fracturing the child's limbs.

Mr. Chicken said it was better to seize the knee than the foot, because it did not necessitate putting the whole hand into the uterus, and the reasons why it was advisable to bring down one knee rather than two were that it afforded a better protection for the cord, and dilated the os more effectually for the future passage of the head.

Mr. Lancaster having replied,

Mr. Chicken proposed a vote of thanks to Mr. Lancaster for his paper. This was seconded by Mr. Harsant, and carried *nem. con.*

A vote of thanks to the Chairman was proposed by Mr. Waterhouse, and seconded by Mr. Fry, and Mr. Cock having briefly replied, the meeting adjourned.

Operations.

Tuesday, Oct. 6th

Mr. Cooper Forster opened a blood tumour situated at the back of the left thigh of a woman aged 17 (No. 8 Charity). The contents were evacuated, the wound syringed out, and carbolic lint applied.

Mr. Bryant removed the right breast of M. M., aged 40, (No, 6 Lydia ward), and characterized it as an operation of expediency. Discussing the probabilities as to the nature of the growth, he discarded the idea that it was either inflammatory or simple, and diagnosed it as cystic carcinoma. After making two elliptical incisions in the direction of the fibres of the pectoralis, he dissected away the whole breast, some fibres of the pectoral muscle being included. Extending the incision into the axilla he removed some enlarged glands; some vessels were twisted, and the widely gaping edges of the wound were adjusted, as far as possible, by strapping. On section, the tumour proved to be encephaloid, involving almost the whole mamma. The operation was far from being bloodless, and more than one of the new men appeared to sympathize with the sufferer.

The theatre being to-day honoured by the presence of Professor Esmarch, the students had the privilege of seeing the elastic bandage, invented by this distinguished man, applied by himself in a case on which Mr. Bryant operated to remove some dead bone from the tibia of a man (No. 25 Accident ward) whose leg had sustained a compound comminuted fracture seven months ago. Two sinues leading down to the dead bone were connected by an incision which was carried up the front part of the leg for six inches. By the aid of a mallet and chisel an inch of new bone was removed, and the dead sequestrum extracted in three pieces

by forceps. The wound having been plugged with lint and cotton-wool, and the limb bandaged, the elastic tourniquet was then removed.

On Wednesday, Mr. Cooper Forster operated on a case of strangulated femoral hernia, describing each step of the operation and treatment, thus commencing his course of Clinical lectures. (See page 18.)

TUESDAY, OCT. 13TH.

Mr. Cooper Forster excised a carcinomatous mammary tumour by an eliptical incision, sutures being subsequently applied.

A woman, aged 49, had a large mammary tumour, not involving the deeper parts or the skin, which was tightly stretched over it, and mappedant with distended veins. On removal, Mr. Bryant found it to be a simple fibroid tumour, allied to the adenoid, not cancerous, although her age would havepointed to this. The diagnosis originally made was thus confirmed.

A girl, aged 22, had a thyroid cyst which had been growing two years, slowly; had been tapped with the aspirator by Mr. Bryant five weeks ago, when a grumous, thick, coffee ground fluid came away. It had rapidly enlarged again, and Mr. Bryant now made a free incision into it, evacuated the contents, which resembled pure blood, sponged out the cyst with perchloride of iron, and left it to granulate up. The cyst instantly contracted after the incision. Its walls were highly inflamed.

Obstetrics.

RETROFLEXION OF THE UTERUS—ABORTION.

M. L., æt. 36, has had seven full-time children, and twice aborted at third month. She conceived in April, and three months after attended Dr. Galabin's out-patients complaining of dragging pains in the stomach and difficulty in micturition. After some weeks' treatment she was admitted into Mary Ward, under Dr. Hicks, who diagnosed a retroflected uterus containing a three months' ovum, probably dead. Uterus appears to have been restored, and patient left the hospital relieved. In a few weeks she experienced continually a cold moist sensation at lower part of stomach, and the womb felt as a dead heavy weight. These symptoms continued till Oct. 8, when an extern was summoned; he found that the labour pains had ceased, and the vagina had been plugged by a Bermondsey doctor on account of hæmorrhage. The Junior was sent for, and finding the patient free from pain and hæmorrhage, and the os not thoroughly dilated, he gave a grain of opium, and soon after the ovum was expelled with its membranes entire. From the history the patient gave, the ovum was diagnosed on examination to have been impregnated in April, and to have died early in July, possibly from the manipulations necessary to restore the retroflected womb. Length 4in., weight 1¾oz. Mouth and eyelids open, anus perceptible, extremities divided into thin separate parts, no signs of decomposition of fœtus, but liq. amnii of a milky colour and fœtid.

RETROFLEXION OF PREGNANT UTERUS.

M. B., æt. 41, has had six full time children, and three times miscarried at four months and a half. With the last two children and the miscarriages, she has suffered from pains in the back and loins, and difficulty of micturition, for some days before labour. On Oct. 8 she came to the out-patients' room, complaining of those symptoms, and was admitted into No. 30, Mary Ward. The bladder was distended so as to form a semi-elastic swelling reaching almost to the umbilicus, and on passing the catheter more than three pints of fœtid, purulent urine were drawn off. The catheter has since been passed night and morning, and the bladder washed out with permanganate lotion. On the 10th patient was placed in the knee-elbow position, and by passing the finger into the rectum and applying continual pressure downwards (*in this position*), and slightly on one side so as to avoid the promonotory of the sacrum, Dr. Galabin succeeded in replacing the uterus aboue the brim. The uterus being enlarged retained this position, and it is hoped the patient will go to the full time.

Out-Patient Room.

A young man presented himself with disease of left hip. The left leg was *apparently* an inch or more shorter than the right, but, on careful measurement, Mr. Howse found it to be an inch and a quarter longer than the right. He considered this to be due to twisting of the lumbar spine, and consequent tilting of the pelvis.

Whenever you get corneo-iritis in a child, regard it as evidence of a specific action.

Difference between hydrocele of the cord and hernia. The former is translucent, gives no impulse on coughing, and is freely moveable above and below. Mr. Howse generally cures the former by a free incision, evacuating the fluid, and inserting a piece of lint soaked in carbolic oil, leaving it in for twenty-four hours or more. The object of the radical cure of hydrocelo is to set up such an amount of adhesive inflammation as shall cause the obliteration of the cavity. Any fluid will do this—even water. Mr. Howse has used port wine lately, as less irritating than tinct. iodine.

Difference between caries and necrosis. The former is molecular death, an ulcerating process; appears mainly at the ends of long bones, in the cuncellous tissue, its appearance in the shaft being very rare. Necrosis is death in pieces, exfoliation a sloughing process; appears in the shaft, being very rare at the articular ends.

Condylomata, when really existing, rapidly wither and disappear, by regularly dusting them with pulo calomelands.

A man, æt. 27, came under Dr. Taylor with well marked gout in the hand. He had a previous attack in the knee (?) none in the toe. His father is very gouty. The difference between gout and rheumatism externally. Gout is of a uniformly dusky purplish red, uniformly swollen; whereas rheumatism is generally pale; or if red, only so in patches, of a rosy blush, and not so uniformly swollen.

The Dissecting-room.

The general appearance of the Dissecting-room has been very much improved this session, by substituting for the rough pieces of wood, on which the names of Dissectors were formerly posted, a series of enamelled tin slips containing neatly printed cards. The tins are hung near the tops of the slates, so that free scope is allowed for demonstrators to illustrate their teaching by means of drawings in chalk. We have discovered that these tins have not been introduced simply to improve the appearance of the room, but in order that the backs of the cards, which they contain, may be utilized for recording notes of abnormalities. Some of these we hope to be allowed to publish during the session. The following gentlemen have been appointed Dissectors:—

ARTERIES: Head and neck and upper—Messrs. Reynolds, Brett. Abdomen and lower—Messrs. Bell, McCarthy.

NERVES: Head and neck and upper—Messrs. Lane, Davies. Abdomen and lower—Messrs. Instone, A. M. Turner.

MUSCLES: Head and neck and upper—Messrs. Meek, Davey. Abdomen and lower—Messrs. Horrocks, J. Poland.

LIGAMENTS—Messrs. Shaw, L. Jones, W. Gray, J. H. Poland.

Clinical Wards.

There is a case of thoracic aneurism in No. 30 bed. Somewhat unusual is the fact that the patient is a female. The aneurism probably involves the ascending aorta, and the pulsation can be both felt and seen on the right of the sternum. There is a loud to and fro bruit which is so marked over the base of the heart, that it was thought the aortic valves must be affected. The sphygmographic tracing, however, is not characteristic of aortic disease, and neither is there any material difference between the right and left radials. There are at present no symptoms indicative of pressure on any important structures, and pain has been her chief and almost only trouble.

The patient in No. 1 bed is suffering from stricture of the œsophagus, probably of a caucerous nature. He is unable to swallow solid food, and can speak only in a whisper. A small sized bougie was passed soon after admission without much difficulty, and others of a larger calibre subsequently. Dr. Habershan has known similar cases greatly benefited by gradual dilatation, the patients having subsequently been enabled to take solid food. Since the above was in type, the patient has so far improved as to be able to swallow fish without it regurgitating, and he describes himself as feeling much better.

No. 24 is a case of typhoid fever in a girl aged 14. The temperature throughout has presented a marked peculiarity; although alternately rising and falling, as usual, the rise has been in the morning and the fall in the evening. There has been an absence of any rash, but the abdominal symptoms leave no doubt as to the true nature of the disease. It may be worth while making a note of the following formula of Dr. Habershon, which was successful in mitigating too free an action of the bowels:—

Acidi tannici	...	5gr.
Glycerini ...	...	℥ 1
Tinc. opii ...	...	10m.
Aquæ ...	...	℥ ½

Fiat inject. cum decoct. amyli.

The worst feature about the case was the severe bronchitis, from which the patient has been suffering since admission. This has now much lessened, as the febrile symptoms have decreased, but it has left some consolidation of the left base.

A SUGGESTION.

By MR. CARLOS DURAN.

One of the unexplained questions of physiology is the reason why inverted images in the retina are perceived erect. Many explanations have been suggested, but none of them are satisfactory.

A simple experiment, which any one can repeat, leads me to suggest what I think is an easy explanation of it. If, while both eyes are closed, any part of the eye is pressed by the finger through the eyelid, far enough backwards to effect an impressionon the retina, a sensation of light is immediately perceived. Not, as we rhould expect, where the eye was pressed, but exactly in the opposite spot; that is, if the eye be pressed on the upper part, the sensation will be perceived in the lower, and vice versa, so that the retina becomes conscious of impressions on the opposite side to which they are produced. If, then, an inverted image is printed on the retina, it is to our feeling just as if it had been printed erect, on account of this remarkable property of the retina. I cannot explain how the retina has this property, but the fact that it exists serves, I think, to explain this obscure question.

Sports.

FOOTBALL.

On Saturday last the Football Club played their opening game at Blackheath. Very few of the veterans played, but there were about twenty-eight who endeavoured to qualify themselves for future honours. On the invitation of the Captain of the Blackheath Club our men joined the club in a "big-side match," which perhaps rendered it rather more difficult to see what individual members could do. One thing is certain, the new men will not be equal to those who entered last year; this, perhaps, was hardly to be expected, but there will, we think, be several useful members to fill up vacancies in the team.

Among the foremost, perhaps, Reader was most noticeable, Keer also played well, Mansell, too, would, we think, prove an addition to the team. Roper, as half-back, made some good runs, and ought decidedly to be further tried, but beyond these there was nothing very striking; of the old members, Gray played as well as ever, and those who have ever seen him play know what this means. Pearson also "dropped" quite up to his old form. The first match will take place to-day in Victoria Park, against King's, who are, we understand, in better form than they were last year, when Guy's scored nine goals against them.

The Wards.

MEDICAL.

The following Cases were admitted between Oct. 8 and Oct. 14.

JOHN.—6—Carcinoma of liver 8—Chloride of zinc poisoning. 9—Enterica, aortic disease. 12—Aortic disease, acute tubal nephritis. 14—Meningitis (?)

MIRIAM.—26, Acute rheumatism—27, Left hemiplegia, rheumatic fever six years ago, mitral regurgitation, embolism. 28—Phthisis.

STEPHEN.—25—Peritonitis, tubercular. 36—Acute rheumatism, first attack. 26—Acute rheumatism, ninth attack. 35—Dyspepsia. 27—Bright's disease. 29—Gout. 30—Gout. 31—Mitral stenosis. 50—Eczema. 19—Chronic rheumatism. 13—Bronchitis, emphysema, phthisis. 17—Diabetes, 1—Right hemiplegia. 12—Acute rheumatism. 11—Chronic rheumatism, enlarged spleen. 11—Albuminuria.

MARY.—23—Phthisis. 13—Abdominal aneurism. 15—Subacute rheumatism. 9—Rheumatic synovitis of knees. 2—Functional paralysis. 1—Cerebral, tubercular meningitis.

ADDISON.—26—Rheumatism, erythema nodosum. 29—Syphilitic psoriasis. 33—Subacute rheumatism. 36—Phthisis. 37—Rheumatism. 39—Gastric ulcer.

PHILIP.—17—Cirrhosis of liver. 21—Typhoid. 23—Empyema. 25—Rheumatism. 31—Myelitis. 33—Pyrexia. 36—Abscess (?) 37—Debility. 40—Bronchitis and morbus cordis. 45—Chorea. 48—Morbus cordis.

BRIGHT.—No admission.

SURGICAL.

The following Cases were admitted between Oct. 8 and Oct. 14.

ACCIDENT.—4—Necrosis of tibia after compound fracture.

CORNELIUS.—3—Concussion of brain, cut head, injury to back. 5—Fractured ribs and emphysema. 7—Fractured femur. 14—Fractured tibia and fibula. 16—Fractured fibula, cut head. 17—Fractured tibia and fibula. 20—Fractured base (?)

LYDIA.—1—Thyroid cyst, incised. 1—Sinuses in perinæum. 10—Osteo arthritis of knee. 23—Cystic, simple tumour of breast.

MARTHA.—1—Embolism of left femoral vein (?)

NAAMAN.—No admissions.

LUKE.—5—Molluscum fibrosum. 10—Strangulated and inguinal hernia, reduced. 12—Diseased shoulder-joint. 15—Old dislocation of shoulder of a month's standing, reduced. 15—Acute synovitis of knee. 16—Femoral hernia. 25—Hydrocele, tapped. 26—Tetanus, death.

LAZARUS.—2—Epithelioma of lower lip. 3—Synovitis of knee-joint. 8—Fistula in ano.

JOB.—3—Adenitis of inferior maxillary glands. 5—Nodes on tibia and tarsus. 11—Hydrocele, radical cure. 21—Synovitis of knee-joint.

DORCAS.—No admissions.

CHARITY.—2—Paralysis of right leg. 6—Fractured femur. 7—Stone in bladder (?) 9—Wound of buttock, secondary hæmorrhage. 12—Carcinoma mammæ. 15—Epithelioma on forehead. 16—Tumour on lower part of tibia. 18—Lupus of nose and face. 24—Fractured tibia and fibula. 27—Smashed hand, amputation of part of hand.

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Guy's Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 4. SATURDAY, OCTOBER 24, 1874. TWOPENCE

AFTER having held, for a decade, the first place in the list of new entries published at the commencement of each winter session, Guy's has had to yield this honour, for two successive years, to St. Bartholomew's Hospital. To no other hospital could we concede this position with so good grace, and we cordially, but with aching hearts, congratulate her upon her success. We are not of those, who borne down by desponding humours, in pessimists' strains would cry "The glory of our school is past, to-morrow we're unknown." Students we have, and teachers too, who will work as others have before, and gain the laurels to which we all aspire. Nor will we allow that either our staff or students fall short in talent of those of any other school. With yearly entries of ninety-five or eighty-six new students, we have little yet to fear, and it is probable that in the aggregate we still retain a majority, owing to the inducements held out to students to remain and reap the advantages of our senior appointments. To what, then, are we to attribute our rival's success, if the reputation of our school remains pre-eminent, and the old love which binds our students keeps as firm a hold on them as ever? Surely some new inducement must have sprung into existence to tempt the waverers to join a sister hospital; and to discover their bait, and extract its sweetness, should be our first duty. Happily, it is not difficult to detect the cause of our neighbour's temporary popularity; for exactly corresponding to the duration of her success, there have been established, by the munificent bequest of one of her Governors, two entrance scholarships, one of £100 and the other of £50. If proof were required of the influence of such honorary rewards upon students undetermined in their choice of a hospital, it is to be found in the fact, that thirty-five gentlemen entered their names last September, for the larger of those two prizes. Having discovered, as we believe, the cause of the change, we would respectfully, but strongly, urge upon those in authority, the advisability of increasing the value of our entrance prizes. But whence, it will be asked, is the capital to be derived to establish such valuable scholarships? "From us, whose fees are yearly lowered to furnish the existing prizes?" will cry the staff—"from Demonstrators whose salary is but £70 per annum?" We confess this does seem hard, and we look around for support from other quarters. Has Guy's, then, no Governors, powerful to aid, and willing to assist in supporting the prosperity of her school? That a governing body exists we are reminded by the prospectus, and it should consist of sixty members. We are told they are noble, and this we justly appreciate. We know they are wealthy, of this there can be no doubt. But of their interest in the students' of this hospital, and of their desire to further the cause of medical education, we have as yet had little experience. True they are elected for hospital administration—to watch the pivot of income and outlay—and with students they may think they have nothing to do. If any take this narrow view of their duties, we would invite them, with all respect, to a wider field, and will assure them that any effort they may make to render the school more prosperous, will be by us and our fellow-students neither ill-requited nor forgotten.

ONE of the most characteristic features of Guy's as a Clinical School is the excellence and completeness of its special departments. We have long been distinguished

from other schools by the special efforts made to ensure adequate clinical teaching in the various minor branches of the profession. While we find men at other hospitals wandering about town to see ophthalmic operations and cutaneous diseases, we have only to visit our own wards and out-patient rooms to find plenty of material for study. It is a matter for congratulation that we have long taken the lead in this respect.

It is with a sincere desire for Guy's still to move in the van, that we wish to call attention to a department in which we, in common with our neighbours, are deficient. We have, practically, no means of studying such diseases as delerium tremens, acute mania, the early stages of paralysis of the insane, and patients generally on the border-land of sanity. That we do see some cases of delirium tremens is indisputable: they come in with broken legs or cut heads, but, if they can possibly travel, they are quickly sent out by the authorities. If by chance we get a case of general paralysis—eliptic mania—who shows suspicious symptoms, or is a little troublesome, he is quickly moved off to that universal receptacle for the common and unclean—the workhouse—to our loss as well as theirs.

The authorities, doubtless, have in mind the greater good of the greater number. They are perfectly right in maintaining that the general wards are not the place for patients who are sleepless and noisy at night, or who show a disposition for cracking skulls. True, in some wards there are private rooms, but the chances are, when they are wanted for the very purpose for which they were designed, there is an ovariotomy, or colotomy, or some other otomy in possession. Have we not a strong-room? There is a place underground, so-called, where the light of day hardly shines, where you can barely see your patient, and where the presiding genius is too often a being who has been called from her world of soap-suds to tend the sick.

Is it not time that Guy's had a separate ward with a few beds and proper male attendants, where a temporarily insane patient could be kept in peace and safety, without frightening some of his fellow-creatures out of their wits, or running a fair chance in company with the hospital authorities of being brought before a coroner? Is there any reason why we should not have a few beds set apart for clinical study of delirium tremens and incipient or early cas of insanity, award where the alienist might bring his stores of learning and experience, and meet the general physician on neutral grounds, to their mutual benefit? We are certain that several of our clinical teachers would enter such a territory as a veritable land of Canaan.

You may answer, you have clinical instruction at Bethlehem, and what is the use of asylums if lunatics are not sent there? Perfectly true, and they are welcome to all the chronic insanity that gin and syphilis ever wrought. But is there no border-country? Is it not alike false in science as in fact, to draw a hard line between the two. Take, for instance, the facts of morbid anatomy. Mark the minute changes taking place in the cords of patients suffering from the group of diseases known as general spinal paralysis, accompanied by a loss of *muscular* sense or by loss of power in the lower extremities, which consists in an increase of the connective tissue and secondary atrophy of nerve-tubule and cell. But let the same changes commence in, or involve the grey matter of the cerebrum, and perhaps the first symptoms are a loss of the *moral sense*, enfeebled powers of the mind, or the boasts of his countless diamonds and unlimited wealth; the one finishes his course in a general hospital or infirmary, the other we lose sight of in a county asylum.

Beyond all doubt, by far the majority of the insane are best and most conveniently treated in an asylum. But that does not alter the fact that we ought to have at a hospital like Guy's an opportunity of studying cases of temporary insanity, or those indefinite nervous cases admitted into the wards who, when they give the smallest trouble or develope mental disturbance, are quickly passed over into the hands of the parish authorities to avoid the responsibility of their detention.

No doubt there would be difficulties, undoubtedly there would be extra expense. But surely there are other questions involved than those of mere arithmetic. It would be valid enough in those hospitals which, to judge from their advertisements, live from hand to mouth, and beg their daily bread from door to door; but Guy's, with its great resources and its noble powers of doing good, without its wants or its cures being paraded in the public press, might manage this little addition to its usefulness without feeling the burden.

In conclusion, we hope that the Medical Staff will represent the matter to the proper quarters, feeling sure that the authorities will give the whole subject their best consideration.

Medical Prayer Union.—The annual meeting will be held at the Freemasons' Hall, on Wednesday, Oct. 25th, at 7·30 p.m. Dr. Habershon will preside, and the Rev. O. H. S. Paterson, M.D., Dr. A. P. Stuart, Dr. Saunders, and others will address the meeting.

Students' Bible Class.—At the annual meeting, held on Thursday, Oct. 15th, it was determined to hold the meetings on alternate Thursdays, at 6 p.m., at Hibernia Chambers, London Bridge. The subject for the session is the Book of Isaiah. All Guy's students are invited to attend.

Clinical Lectures.

ON "SORE THROAT."

By S. O. Habershon, M.D.

(Senior Physician to, nnd Lecturer on Medicine at, the Hospital)

(Concluded.)

Here the disease merely affects the mucous membrane, but in some instances the inflammation is more acute, and you have effusion of false membrane—diptheritic membrane—and here you generally find the tonsils affected as well as the soft palate, and the whole posterior part of the pharynx. In this case the part is more inflamed, and you find little white patches—maybe about the size of a four-penny piece—on the mucous membrane of the tonsils, soft palate, and the whole of the pharynx. This is different from what is often spoken of as "true diptheria;" here the false membrane is simply on the surface, it may be scraped off, and there is no ulceration beneath. In "true" diptheria the membrane is adherent, it affects the whole mucous lining, and there is frequently sloughing. In some cases these little patches are raised, and surrounded by a definite border, and then it is sometimes difficult to distinguish them from true ulceration. In fact they are sometimes spoken of as minute aphthous vesicles, leading to acute inflammation. There is more febrile disturbance than in the two former classes I have spoken of; pungent heat of the skin, quick pulse, and generally dysphagia, greater than dyspnœa. In these cases of diptheritic inflammation the treatment is very similar to what I have before described; but as a rule you will find astringent applications are of less value. Soothe the throat, and keep it clean, allow the patient to gargle with warm water. Then, as to the application of nitrate of silver, I think you will find more harm than good is done in these cases. You cannot apply it over the whole diseased surface. If you could it might be of some value, and you only increase the irritation and distress of your patient. So also with regard to zinc and iron, remedies very useful in some conditions, but certainly not advisable in these cases of acute inflammation. The states I have been describing to you may quickly pass off; they generally run their course in three or four days; but as the severe symptoms subside you may have a relaxed condition of the mucous membrane of the throat left: the uvula appears elongated, the soft palate swollen, so also the tonsils. In some cases this may gradually pass away, but in others it remains as a permanent condition. In some instances, after the acute inflammation has subsided, you will find a granular condition present, irregular projections over the whole posterior part of the pharynx. Some of the veins may be enlarged and prominent. This is merely chronic catarrh of the pharynx, and you will generally find it relieved by astringent gargles and steel. The same relaxed condition may also be produced by the inhalation of certain vapours, and tobacco, and you may often cure it when due to the latter, by persuading your patient to leave off his smoking. It may also be produced by continued speaking, as in the "clergyman's sore throat." In these cases astringent gargles are of great value. We have another form of inflammation of the throat coming on in connection with syphilis. The mucous membrane becomes inflamed, and afterwards ulcerates, especially at the posterior part of the pharynx. You recognise the ulcers by their serpiginous character and definite circular border. In the treatment of this form you find greater benefit from the use of iodide of potassium and bi-chloride of mercury than from the remedies I have before been speaking of. As to inflammation of the tonsils, which is frequently associated with catarrh of the pharynx, it gradually aggravates the distress of your patient; the tonsils swell, and quickly block up the passage, and the dysphagia is gradually increased. There is a greater tendency also to the effusion of a diptheritic membrane. In some cases it may be merely the gland itself that is affected; it then quickly subsides, and the patient soon recovers. If, however, there are repeated attacks the tonsils grow, and remain hypertrophied, and you have that troublesome condition—chronically enlarged tonsils—on every fresh exposure to cold, they become readily inflamed, and produce considerable discomfort to the patient. In other cases the cellular tissue of the tonsil becomes acutely inflamed, proliferates, and pus is formed. It is then called quinsy, Quinsy is produced by suppuration in the cellular tissue of the gland itself, and is only relieved when the abscess bursts or is opened. In some cases of chronic hypertrophy of the tonsil you find great relief from the persistent application of astringents. Some people are very partial to the use of nitrate of silver. The objection to this remedy is that it tends to increase the quantity of blood sent to the part, and so may produce rather an increase in the substance of the tonsil than a diminution. In the patient whose case we have been considering, not only was the mucous membrane of the pharynx inflamed, but also the mucous membrane of the mouth and tongue. And this you find to a greater or less degree in all the varieties I have been describing to you. In this man the whole of the tongue was inflamed and swollen, so that he was scarcely able to close his mouth, there was a condition of sub-acute glossitis induced. There is still another condition you must bear in mind, namely, "post-pharyngeal abscess," a collection of pus behind the mucous membrane of the pharynx. The symptoms are often very severe, and there is generally urgent dysphagia. On carefully examining the throat you may find the mucous membrane is pushed forward, and on pressing the finger against it, you find it soft, you may detect fluctuation. It may often be ruptured by the mere pressure of the finger. There is one source of fallacy, however, in diagnosis. When the glands of the neck are much swollen they will push forward the posterior wall of the pharynx, and simulate an abscess behind the pharynx itself.

Note.—The case referred to is in No. 11 bed, Clinical Ward.

ON CHLOROFORM.

By J. Cooper Forster, M.B., Lond., F.R.C.S.

Surgeon to, and Lecturer on Surgery at, the Hospital.

Mr. Cooper Forster commenced his lecture by stating that chloroform was first used by him at Guy's Hospital in 1848. At that time the subject of anæsthetics was very little understood, and the profession knew nothing whatever of the dangers which accompanied their administration; these, however, have been, and are being, worked out. Now, we do not hesitate to anæsthetize any one, for knowing what dangers exist, we can frustrate them.

There are four anæsthetics which are most convenient, and, therefore, most commonly employed. These are nitrous oxide gas, chloroform, ether, and the bichloride of methylene. The first of these is used in cases where the operation is quickly over, *e.g.*, in opening an abscess or extracting a tooth. Ether was the original anæsthetic agent employed, but it was found to be bulky and inconvenient, and its use was therefore discontinued; lately, however, it has been brought up again. Its re-appearance ought to be welcomed. The bichloride of methylene is a very useful agent, but is somewhat dangerous, owing to the rapidity with which patients are placed under its influence. Chloroform, then, is the agent generally used when a prolonged operation is about to be performed. The question arises: To whom may it be given? It may be given to anyone who wishes to be delivered from pain. This may excite surprise, for there is an opinion prevalent amongst the public that people with diseased hearts ought not to inhale the drug. Mr. Forster believes that, if it is necessary to perform an operation on a patient sufferiug from disease of the heart, it is better to administer chloroform, for there is less danger to be apprehended from the exhibition of the drug than from the dread of the operation. There is a form of cardiac disease—fatty degeneration—which it is impossible to diagnose during life, and when this disease is present there is danger. It ought to be borne in mind that patients have died on the operating-table before chloroform was known. Some surgeons always make a practice of listening to the patient's heart before administering chloroform. This is great nonsense, and an entirely useless piece of formality to go through; for supposing the surgeon were to find anything wrong about the patient's heart, he would not inform the patient of it, and the probabilities are the patient would refuse to be operated upon without chloroform. Mr. Forster wishes to make a strong point of it, that chloroform may be given to patients with cardiac disease; it is a lesson which experience has enforced the conviction that it is true. The administration of chloroform under any circumstance is attended with more or less danger, and the way to obviate this danger is what we, as students, have to study. The golden rule for the administration of chloroform is this: Concentrate your whole undivided attention upon what you are doing. Do not think for one moment about the operation that is going on, or about anything but the way in which your patient is taking chloroform. Inattention and carelessness may cause death. The position of your patient and the condition of his clothes is of the utmost importance. The proper position is the recumbent, and all the clothes should be loosened as much as possible. The patient should be placed flat on his back under all circumstances, because death has occurred from an anæmic condition of the brain, and the horizontal position is the most favourable for a good supply of blood to that organ. In some cases, such as staphyloraphy, and operations about the mouth and face where it is convenient to have the patient in a sitting posture, before he is raised he should be placed perfectly and thoroughly under the influence of the chloroform, and kept so for a few minutes, and then raised to the required position. The clothes should be loosened, so that the respiration and circulation may not be impeded. Mr. Forster called to mind three cases of death from chloroform, in all of which the simple operation for avulsion of the toe-nail was about to be performed. Two of these cases occurred in different hospitals, and one in private. In each instance but slight attention was paid to the patient (the operation being deemed a slight one) the clothes were not loosened, respiration was impeded, and the patient died. Again, the quantity of chloroform given is of no consequence whatever. Give as much or as little as you like. It is not the quantity but the effect produced you must consider. The apparatus used in the administration of chloroform is a matter of taste, for there are twenty or thirty different contrivances invented. A common pocket-handkerchief saturated with chloroform held about half an inch from the patient's nose is to be preferred to all things. This method has a double advantage. Firstly, it allows plenty of atmospheric air to mingle with the chloroform vapour. Secondly, it prevents the chloroform from blistering the patient's face, which it is apt to do if it comes in close contact with the skin. Tell the patient to take seven or eight deep inspirations, and these will probably be sufficient to anæsthetise him. There are three stages. The first is one of suffocation; the patient tosses his head from side to side, and tries to get out of the way of the inhaler; he also complains of smartin gabout the eyes, and should, therefore, always be directed beforehan. to close his eyes. The patient can remember this staged The second stage is noisy, and the patient tries to jump off the couch, and fights about furiously; this is the time of danger, because the chloroformist, in order to get over the existing discomfort, crams on the chloroform, and the patient thus is very apt to get an overdose. Great care should then be taken at this stage, of the two give rather less than more chloroform. Patients never remember this stage. The third stage is the one of quietude and perfect repose, and is favourable therefore for performing the operation. The cornea is now insensitive, the pupil contracted and the muscles completely relaxed. In parturient women it is best not to push the chloroform beyond the first or second stage, because then the assistance derived from the action of the abdominal muscles is retained, and, therefore, their action in expelling the fœtus is of great service. Supposing the operation is over, what are the after consequences which may be looked for? Chloroform has a very different effect upon different people. Some patients are so ill for forty-eight hours afterwards or even more, that when it necessary for any reason to perform a second operation on such persons, the advantage of giving chloroform is much to be questioned. Some patients are not sick at all after its administration, whilst others—and this is the rule—are sick two or three times during the ensuing night, but awake quite well in the morniing. As regards taking food before an operation, it does not matter in the least, for it is quite an open question whether patients are more likely to be sick on a full stomach or an empty stomach. What is to be done when a patient has evidently had an overdose? Send the chloroformist away, for he is imbued with the chloroform vapour; open all the doors and windows, and immediately commence artificial respiration by squeezing the chest; and, having squeezed it, let it again expand. This should be done from twenty to thirty times a minute: at the same time direct an assistant to chafe the limbs, so as to assist the circulation. Apply one pole of a galvanic battery to the pit of the stomach, and the other along the course of the phrenic nerve. Artificial respiration should be kept up at least an hour. Mr. Forster remarked on the great benefit it was to the students of the hospital that there was no appointed chloroformist, but that anæsthetics were always administered in the theatre by the House-surgeon.

THE BURNING OF LADY DILKE'S BODY.

The following interesting account of the cremation of the body of Lady Dilke is abridged from a paragraph in a German paper. On the evening of Friday, October 9th, the first burning of a human body in the oven built by Frederick Siemens in Dresden for that purpose took place. For nearly a fortnight, Lady Dilke's brother-in-law, and the executor of her will, had been in Dresden for the purpose of making arrangements for carrying out the direction which she had given in her will that her body should be burned as a "scientific experiment." The body was embalmed in London four weeks previously, and was transported to Dresden in a coffin surrounded with lead. After the removal of the leaden covering, the condition of the body was examined by the State district physician, in the presence of the President of Police, State Councellor Flath, and others, including Dr. Roth, Dr. Kitchenmeister. Dr. Spitzner, and Engineer Piper. Some minutes after the introduction of the body in its oak coffin, from which the lid had been removed, into the oven, a door was opened, through which the process of burning could be observed in detail. In six minutes, the coffin was observed to be bursting. At the end of ten minntes, the muscular parts were generally broken up; and in scarcely twenty minutes the skeleton was laid bare, and was itself beginning to undergo destruction. The charring of the internal soft parts was remarkably advanced in thirty minutes; and, at the end of an hour, the remains of the bones were greatly reduced. At the end of seventy-five minutes, the remaining ashes, weighing about six pounds, were collected and placed in an urn. —*British Medical Journal.*

DR. ALFRED SWAIN TAYLOR IN THE WITNESS-BOX.

Dr. Swain Taylor, our justly celebrated Professor of Medical Jurisprudence, was summoned, on Monday last, to give evidence at the inquest on the bodies of those killed by the recent explosion in Regent's Park. Dr. Taylor, than whom no one is ever more at home in the witness-box, gave some very valuable evidence concerning the inflammability of benzoline, and when it is considered that the Petroleum Act was founded upon investigations made by him for the Government in 1855, it will be understood how great weight must be attached to any opinions he may express in reference to the late accident. He stated, that benzoline vapours come off at ordinary temperatures, pass readily through cork and other substances, glass only serving to prevent their evaporation. This highly inflammable gas might be readily ignited by anything red-hot, such as a cinder from the tug's chimney, but as there was an open fire on board the Tilbury, he was of opinion that the vapours of benzoline had been drawn from underneath the tarpaulin to the naked flame, and that in this way the explosion had been brought about.

THE RUSH FOR THE INTRODUCTORY LECTURE.

In the last number of the *Pictorial World* there is an engraving representing "the rush" from Guy's to the Bridge House Hotel, which took place on the 1st of October, when so great a crowd collected to hear Sir William Gull's introductory lecture as to necessitate an adjournment from the theatre to a larger hall. The sketch is taken from Thomas's Street, with the hospital gates as a background, and a number of gentlemen, for the most part hatless, are represented as rushing headlong down the street, regardless alike of little boys with matches and of costermongers' donkey-carts. The scene was certainly an extraordinary one, and we do not accuse the artist of exaggeration; but we take exception to the decidedly German cast of countenance he has chosen to do service for students' faces.

HAIR AS A DISTINCTION BETWEEN RACES.

At the late meeting of the French Association for the advancement of Science, held at Lille, a member drew attention to the characteristic differences in the hair of different nations, and contended that the varieties were so distinct as to be sufficient to distinguish one race from another. We think the learned Frenchman would experience some difficulty in classifying, by their cranial coverings alone, certain gentlemen of our acquaintance, who have passed the middle period of life.

THE PHYSICAL SOCIETY.

The second meeting of this Society will be held this evening at 7·30, in the Chemical Theatre, when Mr. Chicken will take the chair, and Mr. Vinter will read a paper upon "Chloral Hydrate."

Operations.

—o—

Tuesday, Oct. 20th.

The first patient placed on the table was suffering from a large swelling over the lower end of the tibia and fibula. The tumour was pulsatile. Mr. Forster thought the diagnosis lay between aneurism and malignant disease, but intended reserving his remarks until the morrow, when the case would form the basis of his clinical lecture. The patient being under the influence of chloroform, and Esmarch's bandage was applied, and a longitudinal incision made through the skin into the tumour. It was found to be malignant, and springing from the bony structure, and involving them so completely as to necessitate amputation. There was difficulty in stopping the hæmorrhage, and at last the point of a hot iron was used.

Mr. Howse brought in a patient, æt. 32, suffering from a small tumour of the breast, which was adherent to the skin. This had been growing for two years. Mr. Howse proposed to remove growth only, on account of its small size. The history and appearance were in favour of the tumour being a chronic induration, but this was negatived by the tumour being still distinctly felt when the hand was placed flat upon the breast. The growth was ultimately removed by two semi-circular incisions an inch and a-half in length. On section, a fluid-like pus escaped, which was opposed to carcinoma. Mr. Howse thought that probably the tumour was a gumma or sarcoma, the microscope, however, would decide. The wound was closed by catgut sutures, and the whole operation performed under the carbolic spray.

In our next week's number we hope to give our readers an account of an interesting operation for excision of the lower jaw, performed by Mr. Howse.

Obstetrics.

—o—

On the 3rd instant, an interesting case of convulsions in a woman, eight months pregnant, was admitted into Mary ward. E. C., æt. 42. Has worked in lead but never suffered from lead colic, although she has now a well-marked blue line. Has lately noticed slight swelling about the

ankles. Never previously had convulsions. This morning fell down in a fit which lasted about five minutes; during the day has had four or five other fits, and has not in the interval been sensible. On admission at 4 p.m., pupils are dilated and insensitive. Pulse 96, feeble; temp. 101. With difficulty kept in bed; during a fit the left side of face is drawn up, foaming at mouth, biting of tongue, &c. Chloroform was fully administered, and by this means patient was kept tolerably quiet for the next six hours. The catheter was passed, and on examination the urine drawn off was found loaded with albumen; no cast, sp. gr. 1010. Os could be felt high up, the size of a shilling; the vertex presenting. At 8 p.m. Dr. Galabin punctured the membranes, and the liquor amnii quickly drained away, when the vertex could be plainly felt per vag., and the breach at the fundus. During the night she remained tolerably quiet and sensible. On the 4th, the urine was only slightly albuminous, sp. gr. 1015. Patient's struggles prevented a thorough examination, and the presentation could not be ascertained. At 9 p.m., the Charity were called to Mary ward. Found patient in a very excited state, with the feet of the child born. Nothing could be done till the patient was thoroughly anæsthetized, when the senior, with some difficulty, released the head of a nearly full time dead child. From this time the patient rapidly improved (with the exception of an epileptiform fit on the second day), and she is now nearly well.

The Surgery.

It has been necessary many times to remove needles from different parts of the body. In some cases the distinct characteristic prominence could be felt. Removal by the forceps was, in these cases, easily accomplished through a small superficial incision over the projection. In others, where there was no guide to the position of the needle, beyond the situation of the pain and the scar of entrance, it has been found best to make a crucial incision over the seat of pain and dissect up the flaps. In this way the foreign body has been easily found when a search through linear incisions has proved fruitless. Esmarch's bandage has been found invaluable, and has always been applied when possible. The definite localisation of pain has invariably served to indicate the position of the needle, even when at a distance from the scar caused by the entrance. When there has been danger of opening a synovial sheath, the carbolic spray has been used without any secondary mischief.

A good many cases of stabbing have come to be dressed. The wounds seem to have been inflicted on slight provocation, and have frequently been in close proximity to large blood vessels, which have, however, as yet, fortunately escaped injury.

A child was brought with a comparatively slight burn on the forearm. Before the accident the boy was reported to have been in good health. There was great collapse and partial insensibility. On this account the patient was admitted, but died in about twelve hours. Death could be attributed to no other cause than the accident, there never being complete recovery from the shock.

Clinical Wards.

An interesting case of cerebellar tumour came to a termination in the *post-mortem* room on the 16th of October. The patient, a married woman, began, in April, 1870, one month after miscarriage, to suffer from pains in the head. This continued till four months before admission, when vomiting set in, and the pain became much more severe. She was admitted into Clinical Ward, July 6, 1874, with severe pain at the back of her head and neck, and across the forehead; slight intolerance of light and sound, some loss of power in arms and legs, thought to be due to wasting of the muscles, and constant sickness; no paralysis.

The following progress of the case may be very briefly noted:—

July 13th. Giddy, and cannot stand without support.

July 16th. Paralysis of external rectus.

July 20th. Hearing slightly less acute. Double vision, due to external strabismus.

July 28th. Sight much worse than on admission, can see her finger only at a distance of about a foot.

August 1. Totally blind.

August 27. Deaf with left ear.

September 17th. Perfectly deaf.

Towards the end of September she became weaker, and was unable to leave her bed. Otherwise she remained in much the same condition till October 15th, when, without any warning, she died somewhat suddenly.

At the *post-mortem*, on the following day, there was found a simple cystic tumour of the cerebellum, containing a slightly albuminous colourless fluid. The cyst measured at least one and a-half inch in diameter, and involved the whole thickness of the cerebellum. It projected into the cavity of the fourth ventricle, from which it was divided by only a very thin layer of brain substance. Dr. Goodhart, who made the *post-mortem*, thought there was no distinct cyst wall. The lateral ventricles were dilated and filled with fluid. The membranes could not be stripped off without lacerating the brain substance. This fact, together with the general dryness of the surface, observed on removal of the brain, and a slight greasiness in parts, was thought to indicate some early meningitis. There was nothing of note in any of the other viscera.

The Dissecting-room.

Since our last report only two bodies have been received, and one of these had been previously examined, so that there are many gentlemen now waiting and growing impatient for "parts." The first year's men seem to be taking a strong interest in their work, and one or two who have come to us from provincial hospitals show a considerable knowledge of bones and muscles.

We understand that all the Exeter students came to Guy's this year, probably owing to the kind influence of Mr. Bankart, who was formerly a Demonstrator of Anatomy at this hosptial.

Sports.

FOOTBALL.

At a meeting held at King's College on Friday, the 16th inst., Mr. Lyne, of St. George's, in the chair, it was agreed that the secretaries of the different hospitals should commence at once to collect subscriptions for the United Hospitals' Challenge Cup £70 or £100 is the amount to be collected, and there ought to be no difficulty in getting this from the nine hospitals which are going to compete for the cup. Guy's should furnish at least £20 towards it, and we think that nearly every student will give a small sum. If the whole amount cannot be obtained this year it was determined not to buy the cup for another year, by which time the money certainly ought to be forthcoming. At the same meeting, Mr. W. E. Collins, of St. George's, was elected captain of the United Hospitals' Football Club, and Mr. F. S. Alford, of University, vice-captain.

Guy's v. King's.

This match was played last Saturday at Victoria Park, and resulted in an easy victory for Guy's by three goals, three tries, and four touchdowns to nothing. Gray and Maclean played well at half-back, and Mutch and Keer were most conspicuous among the forwards. Maclean, Roper, Reader, Mutch and Keer obtained the tries. Gray made a good drop-kick, and secured a goal by it We had only 13 men to our opponent's 15. The following composed the Guy's team :—Backs—Bonsor (captain) and Breach; half-backs—Gray, Maclean and Roper; forwards Hetley, Welchman, Mutch, Wallis, Collins, Reader, and Mansell.

A SUGGESTION.

To the Editors.

Sirs,—Regarding Mr. Duran's Suggestion in last week's *Gazette*, I think it is a pity that gentleman has confined his attention to the retina alone in offering his "easy explanation;" that structure has always appeared to me in the light of a sensitive plate, fitted for receiving impressions only, and not transmitting them. The appreciation of this impression is a totally different thing, and is the work of the brain through the medium of the optic nerve; it is to this latter apparatus, then, that we must look for a solution of this difficult question. In examining this question, the following facts have great significance to me, though I am not prepared to say that they tend altogether to explain the problem. The structure of the eye in all vertebrates is such as to throw an *inverted* image on the retina, and further the fibres of the optic commissure in this sub-kingdom, decusate, as do the motor fibres of the medulla also; thus, then, inverted or wrong-sided images seem to co-existin all animals where the motor power of one side is governed by the nervous centre of the *opposite* side. In invertebrates, on the contrary, only erect images are formed, and motor power in this sub-kingdom is governed by its *own* side. If, then, we are accustomed to use the right side of our brains to govern the actions of the left side of our bodies, so we are accustomed to regard inverted images as erect, and right hand images as if coming from the left hand side of the external world. I would recommend Mr. Duran to a *careful* perusal of p. 242 of "Huxley's Physiology," and, hoping a discussion will be raised on this important point, I beg to remain, &c.,

Nervus Opticus.

Guy's Hospital.

THE JANITOR FUND.

To the Editors.

Sir,—A general meeting was held on Wednesday, Oct. 14, in the Anatomical Theatre. We regret to say that the attendance was very poor. However, it was resolved that the lists should remain open for another week, which will close on Monday next. The amount collected is upwards of £28, but there is yet a sum of £14 which has been promised, but not yet paid. Gentlemen that have promised are kindly requested to send in their subscriptions to

B. Jumeaux,
Honorary Secretary and Treasurer.

The Wards.

MEDICAL.

The following Cases were admitted between Oct. 15 and Oct. 21.

Bright.—14—Enterica.

Philip.—19—Locomotor ataxy. 33—Diabetes.

John.—8—Right pneumonia. 11—Acute rheumatism.

Stephen.—4—Morbus cordis. 24—Left hemiplegia. 33—Acute Bright's disease. 34—Acute phthisis—pneumonia. 35—Lardaceous disease—syphilis.

Mary.—28—Pelvic cellulitis. 33—Retro-uterine swelling—perimetritis? 39—Malignant. 47—Malignant. 49—Subinvolution—urethritis. 50—Ovarian (?)

Mriam.—17—Right pleuritic effusion. 20—Chronic laryngitis. 25—Carcinoma of Liver (?) 32—Acute eczema.

Addison.—4—Pleurisy. 5—Enlarged gland 7—Albuminuria. 8—Acute rheumatism. 17—Psoriasis. 21—Hemi-chorea (left) after rheumatism, no cardiac bruit. 23—Facial erysipelas and fauces. 24—Tonsillitis. 26—Chronic meningitis. 28—Chronic rheumatism—mitral stenosis. 29—Phthisis (tubercular)—diarrhœa. Cot—Submaxillary abscess. 40—Chronic rheumatism.

SURGICAL.

The following Cases were admitted between Oct. 15 and Oct. 21.

Accident.—7—Injury to ribs and head. 7—Concussion of brain—alcoholism. 12—Injury to back. 13—Injury to back. 18—Pott's fracture. 22—Fractured tibia and fibula. 23—Fractured femur. 23—Concussion of brain—alcoholism. 24—Concussion of brain, fractured base (?) 29—Compound fractured patella, lacerated wound of leg.

Cornelius.—5—Fractured superior maxilla—injury to foot. 9—Fractured femur. 12—Injury to abdomen, fractured fibula.

Luke.—8—Synovitis of knee. 10—Carbuncle. 11—Stone in bladder. 12—Necrosis in stump. 18—Eczema of legs.

Lazarus.—19—Necrosis of ulna. 20—Necrosis of humerus.

Dorcas.—Osteo-arthritis. 7—Suppuration round knee-joint. 19—Enlargement of bursa patellæ. 22—Suppurating gland in the groin.

Naaman.—3—Eczema of legs. 5—Necrosis of tarsus. 11—Strictured urethra. 13—Strictured urethra. 14—Necrosis of superior maxilla. 15—Senile gengrene of great toe—apoplexy. 16—Necrosis of tibia. 17—Synovitis of elbow. 22—Morbus coxæ, abscess.

Charity.—7—Osteitis of femur. 11—Ulcers on leg. 13—Burns 21—Tumour of breast, removed.

Lydia.—2—Anchyloais of knee. 3—Burn. 5—Cicatrix after burn. 15—Epithelioma on nose. 21—Ovarian tumour. 22—Impacted fracture of neck of femur. 27—Talipes.

Job.—2—Scald. 7—Fractured inferior maxilla. 8—Lacerated wound over patella. 9—Stone in bladder—lithotomy. 11—Ulcer on foot. 15—Stricture of urethra—enlarged prostate. 18—Synovitis of knee. 20—Ruptured urethra. 21—Laceration of hand, amputation of finger. 22—Stone in bladder.

Martha.—No admissions.

ANSWERS TO CORRESPONDENTS.

A.C.B. writes to us to complain that the Committee of the Janitor's Fund have given no account of their doings this session. He understands that, of £43 promised, only £28 have been received by the Committee, and suggests that those who have promised and not paid should be published in the "Gazette." We could not, however, make our columns a pillory for debtors.

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Printed for the Presidents of the Physical Society by ORLANDO G. BRIMMER, of 104, Borough, S.E

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A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 5. SATURDAY, OCTOBER 31, 1874. TWOPENCE

Lectures on Midwifery.

By J. BRAXTON HICKS, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

LECTURE I.

ANATOMY OF THE PELVIS AND FŒTAL HEAD.—The pelvis is situated outside the parturient canal. It influences to a large extent natural labour, and when distorted is one of the great causes of dystochia or difficult labour. The pelvis is an excellent instance of an organ subservient to a large number of different functions, acting independently of one another. First, there are two strong arches which support the body in its positions, one in the erect the other in the sitting posture, the former reaching from the acetabulum to the base of the sacrum; the latter from the tuber ischii through the solid position of the bone to the same point. The sacrum is said to be the keystone of the arch, but this is a mistake: when the force of the body comes down on the sacrum, the sacrum would fall through were it not for some slight irregularities, supported by the parts of the joints. The pelvis is the centre of movement of the body, and besides this it possesses a cavity for the retention of the pelvic viscera, and forms a canal through which the fœtus has to pass. The process by which the child has to pass through this passage is called the "mechanism of labour." The two pubic bones joined together form the arch; this varies considerably in the male and female: in the former it is more acute, in the latter it is more widely spread out. If the female pelvis approaches that of the male it becomes very difficult for the head to pass under the arch. It is driven back towards the coccyx, and thus necessarily bears down upon the perinæum and tends to cause its rupture.

THE ARTICULATION.—The coccyx, with the sacrum, forms a ginglymus; this is important, because it may become anchylosed, and sometimes with the coccyx, when curved too much forwards forms an obstacle to the advance of the child's head; and sometimes outwards, when it is the cause of great inconvenience and pain in sitting down. The other two joints, the sacro-iliac and inter-pubic symphises are amphiarthroses: the latter has a partial synovial membrane, and becomes relaxed during pregnancy and for a month or two after labour. The only ligaments of general importance are the sacro-sciatic, and of these the one that goes to the tuber ischii is of the most consequence.

THE PELVIS is divided into two parts: the true and the false. The ileo-pectineal line is the division between the two; all above that is the false pelvis, and all below that the true. The true pelvis is divided into three parts: the inlet, the cavity (properly so-called), and the outlet. The planes of the pelvis are imaginary levels at certain points. The plane of the brim is the inlet, the plane of the outlet is very irregular in every way. The plane of the cavity is a line drawn from the centre of the symphisis back to the centre of the sacrum. The axes of the pelvis are at right angles to these, through the centre of each plane. Round the symphisis pubis everything must pass, the major friction is there, whatever part of the fœtus touches that is retarded. The centre of the curve of the cavity is a little outside the symphisis. The axis of the brim inclines towards the horizontal at an angle of 30 deg., the plane of the brim at an angle of 60 deg.

THE TRANSVERSE DIAMETER is the largest in the bony, the oblique in the clothed pelvis. This is owing to the encroachment of the iliac and psoas muscles. The left oblique is less than the right on account of the rectum.

The cavity is about uniform in all its diameters, 4½ to 5in. The more shallow the pelvis the more feminine it is in type. The oblique is the longest diameter of the outlet, and hence

the long diameter of the fœtal head takes this position on emerging. The following are the measurements of the pelvis:—

	Antero posterior.	Transverse.	Oblique.
Inlet	4½	5¼	5
Cavity		4¼ to 5	
Outlet	4 to 5	4	4¼

Fœtal Head.—Measurements: Longitudinal, 4-4½; Bi-parietal, 3½-4; Bi-zygomatic, 2½-3; Fronto-mental, 3½; Fronto-bregmatic, 3½; Occipito-bregmatic, 4¼.

The shape is ovoid; one part, the calvareum, is compressible, the other, the base, is incompressible. The breadth of the shoulders is about five inches, generally being about the same size as the hips.

Expulsive Forces in Parturition.—The force which expels the contents of the uterus is two-fold. Firstly, the contraction of the muscular structure of the uterus in itself. Secondly, the contraction of the abdominal muscles or the auxilliary force. The uterus derives its nervous supply from ihe cerebrum, spinal cord and the ganglionic system, the latter being the chief source of its motor power. Hence the uterus can contract independently of the will and is little influenced by paralysis of the cerebro-spinal system. The wave of contraction commences at the cervix, by which means the contents of the cavity are forced to the fundus, and thus the body is excited to action and the wave is completed.

The os uteri is dilated by—1. Mechanical distension; 2. Mechanical dilatation; 3. Physiological yielding. Mechanical distension is accomplished by the pressure of the uterine contents, the mechanical dilatation by the contraction of the longitudinal fibres of the uterus, the physiological yielding by a relaxation of the os. The intrinsic uterine force is greater at the commencement of labour, but in the later stages, as the fœtus escapes, it acts to less advantage. On the other hand the power exerted by the abdominal muscles so increases by the increased reflex stimulus, caused by the greater area of irritation as the head passes down, that when the head is about leaving the vulva the maximum is reached. Expulsive force of the uterus has been computed as equal to 54lb., that of the auxilliary muscles 577lb.; the latter force, to my mind, is overrated, at least as regards practice. If, when the child's head is extruded from the uterus an obstacle is met with, the direction of the uterine force is reversed, pressure is put upon the upper portion, and thus its own fibres may be ruptured or the walls of the vagina torn through. Then the whole of the resistance rests in the round ligaments, and if these give way the uterus is almost wholly separated from its attachments. The action of the abdominal muscles is the great safeguard againt this by preventing the recoil of the uterus. The action of the uterus alone, normally exerted, is to open the os uteri and expel the fœtal head. And, although doubtless, it is able of itself to expel the fœtus altogether, yet when the head is escaping, the auxiliary force comes in to its assistance, so that as the resistance increases so does the intensity and area of reflex irritation, and thus the maximum of expulsive force is reached when the head has arrived at the point of the greatest obstacle. But at this point the force exerted by the uterus is at its minimum, while that put forth by the auxiliary forces are at their maximum; when chloroform is given the force of the auxiliary is much reduced. But so also is the resistance so that labour it not much interfered with as to duration.

Physical Society.

—o—

At the meeting of the Physical Society held October 24th, Mr. Chicken in the chair, a paper was read by Mr. Vinter, on "Chloral Hydrate." The following is an abstract of the paper:—

Mr. Vinter first gave a sketch of the discovery and manufacture of Chloral, and remarked on the rapidity with which it had risen into public favour, the enormous quantity consumed, and the peculiarities which had caused its popularity. Its physical and chemical properties were discussed, and its action compared with opium and hypnotics. Mr. Vinter thought its action was due to its conversion into chloroform by means of the alkalinity of the blood, and justified his conviction by post-mortem examinations. He thought that although its selection as an anæsthetic would not be judicious, no one could call into question its valuable properties as a sedative and narcotic. Evidence with regard to its efficiency in the puerperal state was unsatisfactory. He remarked on its effect of lowering the temperature, and gave the results of observation he had made after taking the drug himself. Fifteen or twenty grains repeated at intervals seemed to him a proper dose, although instances were on record of patients taking two drachms without fatal effects. The use of Chloral in different diseases was next spoken of, also the different modes of administering it. The different morbid effects likely to follow its use were considered, and the antidotes that had been recommended in case of an overdose.

Mr. Lancaster commenced the discussion by remarking on the importance of the subject brought before them by Mr. Vinter. It had been shown, he said, by Dr. Gamgee that the alkalies in the blood were not sufficient to convert the chloral into chloroform, and the same amount of chloroform would not produce similar effects upon the animal economy. Chloral was likely to be useful in the first stage of labour, but it would not be efficient as an anæsthetic; not only the temperature, but the pulse and respirations were also lowered by it. It had been shown to be an antidote in strychnia poisoning. In some cases it produced papular eruptions, or a condition like purpura, in others dyspnœa. He cited two cases that had occurred in the hospital where the use of chloral was followed by eruptions, and a third where it had produced symptoms resembling paraplegia. He had found a record of one case where twenty grains had caused death, and a dose of nine grains had been followed by serious symptoms. It was unadvisable to give it continuously for any length of time. It possessed great advantages over opium in some cases, but it required careful watching.

Mr. Shadwell knew a case in private practice of a gentleman suffering from neuralgia, who took fifteen grains of chloral every night for three weeks, at the end of which time he began to complain of sore throat, and a red rash appeared over the face, neck, and shoulders, very suggestive of scarlet fever: the chloral was stopped, and the symptoms subsided. On repeating it some while after, the same rash appeared, but this time the patient was covered from head to foot; he had also swelling of the sub-maxiliary and parotid glands, and a discharge from the eyes of a viscid character. On the authority of Dr. Taylor, he gave a case of recovery after 160 grains had been taken, while in a girl of twenty, twenty grains had proved fatal. In fatal cases the heart seemed to stop during dyastole. Mr. Shadwell then narrated at some length a case reported in the *Lancet* where a change in the vehicle used to dissolve the chloral had been followed by marked symptoms, from which it had

been suggested that the effects produced depended in some measure upon the rate of absorption.

Mr. Coley remarked, with regard to fatal results from moderate doses, that the cases were mostly those where the patients had taken the chloral of their own accord, and therefore they ought to be very cautious in accepting their doses as correct. He would like to know whether death occurred from coma or syncope, and whether death from chloral resembled death from chloroform. If this latter were the case, it would go, perhaps, a little in favour of the view that the action of chloral depended upon its conversion into chloroform in the blood, and if so the indications and contra-indications, for chloroform would be also those of chloral. The cases most appropriate for the administration of chloral were cases of "idiopathic insomnia," want of sleep without anything to account for it but the state of the nervous system, and perhaps of the mind. He had used it himself once in such a case, with a most satisfactory result. In remarking on its effect on the temperature, Mr. Coley called attention to the fact that the superficial capillaries were injected and the temperature was lowered, while in the experiment of division of the sympathetic the capillaries were also dilated, but the temperature was raised.

Mr. Whitworth referred to cases in the *Lancet* of bronchial affections where the administration of chloral had been followed by ill effects.

Mr. Harsant, while agreeing in the main with Mr. Coley that the cases most suitable for the administration of chloral were those of "idiopathic insomnia," wished to know whether he would include under that title those cases where the patient had been accustomed to the use of stimulants, as he himself thought that in such chloral was remarkably useful. One objection to the drug was its familiarity with the public. When it first came up, accounts were written about it in the public papers, and it seemed to fascinate the public mind, and people used to experiment with it, and the professor did not know to what extent old people—and especially old women—were accustomed to take it. He thought in some cases contrary to what Mr. Vinter had said, that it had an effect upon the head, and he cited an example where it always produced excitement followed by a severe head-ache, while morphia, on the contrary, produced a comfortable sleep.

Mr. McCarthy said that if they only administered chloral in cases of "idiopathic insomnia" it was rather limiting its use. His experience was the reverse of Mr. Harsant's. A patient who had taken morphia to procure sleep was so miserable that he begged that no more should be given to to him, but the administration of chloral was not followed by any disagreeable symptoms. He thought it would be very useful given in small doses in cases of tedious labour. Under any circumstances great care should always be taken in giving the first dose. He described at length a case of acute mania reported by a German doctor, where chloral was given for ten weeks, beginning with small doses and gradually increasing up to 70 grains. On the tenth day a rash appeared, which afterwards very much altered in appearance. About the middle of the time a febrile state set in, the temperature and pulse rising. After the sixth week suppuration began in the axilliary glands, and also in various other glands, and went on until the tenth week, when the chloral was stopped. It presented towards the end of the time a fair case of blood poisoning.

Mr. Lamb described the changes produced by the drug as seen in the retina. First, the capillaries dilate when the action is similar to that produced by division of the sympathetic, then, further there is contraction when the sedative effect ensues, and finally the capillaries return to their natural condition. The lowering of the temperature probably depends upon the contraction. Chloral given in small doses relieves the pain in cancer without having a sedative effect. It was of considerable value, he remembered, in cases of chorea, tetanus, and acute mania, but the chief defect was the uncertainty of its action.

Mr. Rees had noticed that in several cases where the patients had died from chloral, they were taking the same doses they had commenced with; it seemed to produce its effect suddenly. During sleep from chloral the pupil was contracted, but immediately on wakening the patient it dilated again. He had heard of 160 grains being given with impunity. When combined with morphia it seemed to have a very good effect.

Mr. Symonds wondered whether the alkalinity of the saliva, either alone or combined with that of the blood, would be sufficient to effect the decomposition of chloral, and suggested that chloral being a substance easily oxidized in the blood, might be converted into chloracetic acid.

Mr. Brett stated that Dr. Savage mentioned chloral as being almost a specific in cases of epilepsy and epileptic mania; as chloral acted as a caustic, it should not be given when there is any ulceration of the pharynx or mucous membrane of the intestine. He had not heard that its subcutaneous injection caused sloughing of the part.

Mr. Gathergood knew one case where hyperdermic injection had caused sloughing. Had seen it given in the country in ague during the severe attacks of head-ache, and with very good effect.

Mr. Kidd remembered that chloral might be taken for some time without causing any bad symptoms, but on any stimulus being given it was liable suddenly to produce its ill effects.

Mr, Fry observed, on authority of Ringer, that an excessive dose of hydrate of chloral had produced a fall of temperature of eight degrees. Chloral resembled ergotine, in the fact that it caused sloughing when injected subcutaneously.

Mr. Reynolds said it had lately been shown that the pupil was dilated during the use of chloroform, and contracted during the use of chloral, therefore it did not seem probable that chloral owed its effects to conversion into chloroform. He had heard of a rash more resembling measles than anything else following its use. The difference in its effects might depend upon the quantity of the drug. Mr. Vinter had not stated how it acted in sea-sickness, whether by affecting the stomach or by inducing sleep.

Mr. Morgan wished to know what kind of thermometer Mr. Vinter had employed, as those commonly in use registered the highest temperature and not the lowest.

Mr. Jones said that Dr. Debus was of opinion that chloral was used in the adulteration of beer. Its use amongst the public might be diminished since a paragraph appeared in one of the papers speaking of its ill effects. As to the diminution of temperature, might it not be produced before the dilatation of the vessels which had been noticed in the rashes observed? A preparation used hypodermically was made with glycerine.

Mr. Vinter having replied,

A vote of thanks to him for his paper was proposed by Mr. Jones, seconded by Mr. Lamb, and carried unanimously. The meeting then adjourned.

Report of a Case.

J. P., æt. 47, miner, admitted October 10th inst. No. 3 bed, Lazarus ward; under care of Mr. Howse.

Family History good.

History.—Twelve years ago noticed a pimple on right side of the lower lip. For two years this remained quiet, then began to increase, and it was cut out by a surgeon. During the ensuing six years it kept re-appearing, and he, for a time, treated the sore successfully with caustics. For the last two years the growth has been rapid and the pain great.

On admission.—On the right side of the lower lip there is a gap about two-thirds of an inch in length and a quarter of an inch deep; this is caused by the wound of excision and the subsequent application of caustics. On the right border of this there is a malignant growth extending for an inch along the right side of the mouth over the lip and gums. There are hard nodules to be felt in the lower lip along the left side of the mouth. There is also at the left angle of the mouth a malignant nodule, around which all the tissues are infiltrated as far back as the first molar tooth. There are no glandular enlargements on either side of the neck. The constitutional symptoms are getting severe. Mr. Howse urged an operation, and the patient consented.

Operation, Oct. 16th.—The patient being under chloroform (administered with Junka's inhaler) the tongue was transfixed and drawn forward. The first incision was made from the right angle of the mouth to the edge of the angle of the lower jaw. On the same side a second incision from the symphisis of the lower jaw was made along the lower edge of the jaw to meet the first at the right angle of the jaw. A third incision was then made from the symphisis along the lower edge of the jaw to the left angle, and from this point a straight cut was made to the angle of the mouth, thus taking away all the lower lip from the angles of the mouth back to the angles of the jaw, and downwards as far as the mental process. The left ramus was next sawn through, immediately behind the last molar, in a direction slightly backwards, terminating anterior to the angle of the jaw, which was left *in situ*. The periosteum was separated from the inner aspect of the bone, the soft part adherent to the jaw divided, and the loose jaw turned out. The lower flap of skin which had formed the under aspect of the chin was then brought up, and its outer thirds on each side were attached by silk sutures to the superior flaps extending from the angles of the mouth to the angles of the jaw, the middle third being left to form a new lower lip. The ligature passing through the tongue was strapped to the forehead. The hæmorrhage during the operation was slight.

Oct. 17. Passed a quiet night. Fed with iced milk by means of tube passed into stomach. Takes 20oz. of milk four times daily. Temp. 99·4.

Oct. 18. Temp. 98·7. Is comfortable. No symptoms. Still fed as before. Bowels not acted.

Oct. 21. Ligature holding tongue has been loosened. Stitches removed from wound on each side of mouth.

Oct. 26. To be fed with beef-tea instead of milk at night.

The patient is progressing most favourably, having only had slight pain since the operation. Is still fed by means of a tube. Sleeps well. Temperature normal.

Operations.

Friday, Oct. 23.

Mr. Cooper Forster, with the galvanic cautery, removed several of those curious growths known as molluscum fibrosum, from the back of a middle-aged man. The hæmorrhage was slight. They varied in size from a common nut to the size of a man's fist; had been growing for fifteen years, despite of ligatures, setons, and even previous excisions.

Mr. Bryant removed a cancerous mass, with flattened surface and everted edges, 3in. by 2in. from the nose of an elderly woman, whose mother died from cancer. The growth was encroaching on the left eye, and had grown rapidly; considerably even in the week she had been in the hospital. The knife was used and afterwards the galvanic cautery to ensure complete removal. It was found to grow from the periosteum. The nasal bones were intact.

Mr. Durham had a case of a woman, æt. 52, whose breast he removed last July for a cancerous growth. She had had perfect health since, but a short time ago she noticed a small lump just above the old cicatrix. Mr. Durham now removed this by an eliptical incision. It was the size of a horsebean. On further examination, however, the growth was found to extend far into the axilla, and to be so intimately adherent to the axillary vein as to render its removal extremely difficult. Considerable hæmorrhage occurred during the operation. The woman is now doing perfectly well.

Mr. Howse afterwards, in Astley Cooper Ward, opened up sinuses connected with the cœcum. The whole of the structures attached to the anterior superiar spine were divided and a gaping wound was produced, but in spite of this Mr. Howse anticipated a good result.

Tuesday, Oct. 27th.

Mr. Bryant removed several large lymph-adenomatous tumours from the neck of a man by horizontal incisions, enucleating them with as little dissection as possible. On section the tumours were, unlike carcinoma, of a pinkish tint, and presented all the characters of a lymphadenoma. As there had not been detected any excess of white corpuscles in the blood, Mr. Bryant said he thought it would prove to be lymphadenoma, and not leucocythœmia. A drainage tube was left in, and a pad of lint applied.

A man, sixteen months ago, had a compound comminuted fracture of the tibia. When Mr. Bryant first saw him, in August last, he found an oblique un-united fracture of the tibia two inches above the malleolus, with some amount of mobility. The upper fragment over-rode the lower. Mr. Bryant now passed a narrow knife vertically down to the fracture, destroyed with ease the connecting tissue between the fragments, and drilled through both fragments in three places with the archimidean drill. Dry lint strapping and an immoveable apparatus subsequently applied.

Mr. Durham amputated, by long anterior and posterior flaps, through the thigh of a man at the junction of the lower and middle thirds. Twelve years ago the man had rheumatism in the knee; an abscess formed, was opened by Mr. Birkett, and a quantity of pus evacuated. He had never felt any ill effects, and was quite well till last Christmas, when another abscess formed, was lanced, pus evacuated, and since then the knee had become contracted, and was now bent nearly at a right angle. The lower end of the femur was much thickened.

REGISTERED STUDENTS.

The following list shows the number of Students belonging to the various metropolitan schools, who have registered during the present month at the Royal College of Surgeons;—

	First Year.	Second Year.	Third and Fourth Years.	Total.
Guy's	85	81	136	302
St. Bartholomew's	106	85	119	310
Charing Cross	20	17	17	54
St. George's	37	37	52	126
King's College	25	39	66	124
London	31	35	45	111
St. Mary's	30	18	34	82
Middlesex	31	36	24	91
St. Thomas's	56	54	84	194
University College	82	64	142	288
Westminster	8	11	10	29
Totals	511	477	723	1711

MR. JOHN BRIGHT AND VACCINATION.

That every fool should be allowed to have his own way and be empowered to slay his neighbours, because through his ignorance and superstition he objects to vaccination, is Mr. Bright's latest notion on freedom. The anti-vaccinators must have been highly delighted when his letter was read by the Secretary of their Conference on Monday last. "I have always felt that the law which inflicts any penalty on the parent who is unwilling to have his child vaccinated is monstrous, and ought to be repealed" writes the great agitator. If Mr. Bright could have his way, the pig-headed opponents of vaccination would be allowed once more to sow their seeds of virulent infection broad-cast throughout the nation. The letter is a curious indication of the old agitator's policy—to sacrifice the safety of the multitude to the freedom of the individual.

EVELINA HOSPITAL.

The House-Surgeoncy of this Hospital has become vacant by the resignation of Mr. Douglas W. Giffard. Two Guy's men—Mr. Paley and Mr. Manser—are said to be applicants for the office. The latter has held more appointments at Guy's, and is just now finishing his House-Surgeoncy; but Mr. Paley has the advantage of being at the present time Registrar and Chloroformist to the Evelina Hospital. There will probably be a great many candidates from other schools, so that both may be disappointed, but we hope one or the other may gain the appoitmentn.

SCARLET FEVER.

The epidemic of scarlet fever, which has broken out in the metropolis, shows at present no signs of decline. During the past fortnight it caused 22 deaths in Whitechapel, 6 in Hackney, 7 in Belgravia, and 18 in St. Pancras. In the latter district it is accountable for 52 per cent. of the deaths. It has found its way into our own hospital, where two Sisters are suffering from its effects, and we understand that as many as five children have taken the fever whilst patients in the Evelina Hospital.

THE PHYSICAL SOCIETY.

Gentlemen have come forward so readily with papers this session that there is already a subject fixed for every meeting. The Honorary Secretaries have, we understand, ordered cards to be printed, which will bear the names of readers, the titles of the papers, and the dates on which they are to be read. These will be circulated amongst the members of the society, and will be found, we think, most useful.

GUY'S HOSPITAL LIBRARY

Obstetrics.

On the 25th inst., A. B., æt. 18, was confined of her first child. She had an easy labour and did well till the second evening, when she was restless, sick, and complained of pain in the stomach. Next morning she was very feverish, Pulse 128; temp. 104·8; slight tenderness over the abdomen, furred tongue, great thirst, lochia abundant, milk scarce, bowels not moved since labour. Hot fomentations were applied to the abdomen, and Tr. Opii m. x., ex. Mist. Ammon. Acet. 1 ℥ every four hours. In the evening the temp. was a trifle higher. Quiniæ sulph. v gr. every four hours was ordered, and Ol. Ricini 1 ℥ c. Tr. Opii. mxx. statim. On the 23rd she was much better, had slept well, and the bowels had acted freely without medicine. The milk also was plentiful; pulse 120, temp. 103·3, 31; two powders had been taken. In the evening the temp. was the same, but next day it had fallen to 99·6. The bowels had again acted, and the abdominal tenderness had ceased. Tongue clean and moist; milk abundant. The temp. remained about a degree above normal for two or three days, patient improving meantime, and she is now convalescent. The interest of this case was first in the cause of the high temperature, and, secondly, in the reason for its speedy fall. So high a temperature as 105 deg. within forty-eight hours of delivery can scarcely be accounted for by the breast or bowels, for it is seldom the milk is plentiful before the third day, and the bowels rarely act so soon without medicine; but in the face of this is the fact, that no sooner did the bowels act freely and the milk appear in good quantity than the feverish symptoms abated.

In the Guy's Hospital Reports for 1872, Dr. Hicks presents "A Record of Observations of Temperature during Parturition and the Puerperal State." Thirty-three unselected cases are reported in which various causes appear to have influenced the temperature, but in by far the greater number the rapid fall of temperature on the appearance of milk in abundance, or as soon as the bowels have acted incontestibly, proves that the symptoms were due to one of these causes. In the most typical case reported (13) the temperature ranged between 103 and 104 from the third to the fifth day, and fell rapidly on the sixth day. The only remark made on this case is "lactation profuse third to end of fifth day."

Out-Patient Room.

Gonorrhœal Rheumatism.

It is important to clearly diagnose this. The history is not always reliable, as patients will conceal any history of gonorrhœa, though admitting a history of rheumatism. It is a difficult and tedious affection to cure. If you give

colchicum, as for gout, or alkalies, lime-juice, &c., as for rheumatism, you will do more harm than good.

Tonics, especially if any gleet remain, the Tinct. Ferri Perchlor, good living, cod-liver oil, &c., are the best remedies. In these cases you may tell your patients two things. First, having once got rid of it they will not have a return, unless they get a fresh attack of gonorrhœa; and second, their hearts will not become affected as a consequence of the disease.

Sweating in Phthisis.

Dr. Pye-Smith finds the following useful as a check:—

Zinci Oxyd. gr. ij, vel. iij.
Ext. Hyoscyam gr. ij, vel. iij.

In typical cases of locomotor ataxy, it is rare to find the bladder affected; but in less marked cases, which perhaps may not be cases of true ataxy, it is often found so affected.

Chronic Dyspepsia.

The majority of people who suffer from this are young adults. It is comparatively rare to find it in old men, or in old women, except at the climacteric period, and then they get rid of it after sixty.

In left hemiplegia it is not usual to get aphasia.

Most persons can take the Ol. Morrhuæ better alone than in the form of a mixture. Children, however, can generally take it with Vin. Ferri.

Correspondence.

A SUGGESTION.

To the Editors.

Gentlemen,—The "Suggestion" which appeared in your number of the 17th inst. can scarcely be called new. If the writer will refer to the notes of Physiology Lectures, published in this *Gazette* during the earlier months of the year, he will find the bearings of his experiment pointed out in Lecture XII, (June 27th). As remarked, too, by "Nervus Opticus," there is a clear and reiterated statement of the facts of the case in the tenth lesson of "Huxley's Physiology, whilst in "Kirkes'" (and, I imagine, in every physiology book) a more or less clear statement of the "Empirical theory of vision" is to be found.

But, in truth, the experiment of irritating one portion of the retina does not "explain" anything at all; it is simply an example of the fact that stimulation of a given part of the retina (whether by mechanical irritation or by light) produces a sensation, which is referred to that part of the field of vision which is situated in the extension of a straight line joining the part of the retina stimulated, with the centre of the crystalline lens. The "remarkable property of the retina" consists, not in its becoming "conscious of impressions on the opposite side to that on which they are produced"—for, indeed, the retina has no power of consciousness whatever—but in its translating *impressions* of any stimulus into the *sensation* of light. Nor is it "to the optic nerve that we must look for a solution of the question," as your correspondent of last week affirms; for the function of the optic nerve is restricted to the conveyance of the sensation communicated to it by its end-organ; and, doubtless, it would equally well convey the sensation of heat, touch, and sound, were it possible to connect it with the proper end-organs of these senses instead of that of sight. We have to go further yet before we reach the seat of perception. The grey centres connected with the optic tract are charged with this function of transmuting the sensation of light into *perception*, and it is, I suppose, necessary to go still one step higher, to the cerebral hemispheres, before we reach the seat of *conscious* perception, the legion where the perception can be compared with former perceptions, and where judgments can be formed from its comparison with perceptions formed by the agency of the nervous apparatus of the other senses. The fact is, that what we "see" is not the (inverted) image on the retina, but the (erect) object of vision, "seeing" being itself a complex action consisting of 1. An impression on the end-organ of sight—the retina. 2. The translation by the retina of this *sign* from the external world into the sensation of light (with its quality, intensity, &c.) 3. The transmission of this sensation by the afferent —optic—nerve to its nerve centres. 4. The reception of this sensation by the optic centres, and 5. The conscious perception by the hemispheres of the change which has taken place in the ganglion cells of these optic centres.

What, then, ultimately, has the position of the image on the retina to do with conscious perception? Simply nothing in kind: for what is *perceived* is a (presumed) change in certain ganglion cells of the brain, which change the mind (the hemispheres) comes, as a matter of experience, to attribute to the existence in space of an object having certain characters of form, size, colour, locality, &c.

Regretting that I have not the faculty of putting word-signs in a more easily perceptible form,

I remain, Gentlemen, yours, &c.,

Centrum.

Guy's Hospital, Oct. 23, 1874.

Sports.

FOOTBALL.

Last Saturday, in beautiful weather, two fifteens of the Guy's Football Club were engaged in matches on Blackheath.

The first fifteen encountered a very formidable team of the Blackheath Club, comprising several members of the English Twenty, and, although the latter were victorious, our men acquitted themselves remarkably well, auguring very favourably for Guy's in the forthcoming matches for the championship of the hospitals.

The ball was started by Gray at 3·35, and in a very few minutes both sides settled down to real hard work. It soon became evident that this match would prove—as it generally has done—a game of forwards. Guy's were slightly heavier forward than their opponents, and, favoured by the hill gradually worked the ball towards the Blackheath quarters. It was however soon returned by some good dropping from the Blackheath half-backs into the centre of the ground; and although it several times hovered in dangerous proximity to the Blackheath goal, nothing whatever was scored up to half-time.

During the latter half of the game, with the hill in their favour, the Blackheath men had slightly the advantage, and although the Guy's forwards disputed every inch of ground, we were twice compelled to touch down in self-defence. About ten minutes before "no side" was called, one of the

Blackheath forwards made a fair catch right in front of our goal, the place was entrusted to Stokes, who kicked a fine goal, thus winning the match for Blackheath. Although we thus lost the match by this piece of ill-luck, yet every one agreed that our men never played better. The forwards were especially good, going into the scrimmages well behind one another, Pinching and Mutch being particularly noticeable. Gray played well, as usual, although he hardly had a chance of doing anything. Breach made one or two capital runs. For Blackheath, Rawson, Pearson, and Stokes, by their excellent dropping, contributed greatly to the success of their side. The following composed the Guy's team: Forwards—Pinching (captain), Bonsor, Gibb, H. Duke, Mutch, Wallis, Keer, Gilbert, Welchman, Hetley, and Collins. Half-backs—Maclean and Finch, Three-quarter-back—Gray. Backs—Breach, and A. W. Pearson.

ROYAL COLLEGE OF PHYSICIANS.

At recent examinations for the Licence of the Royal College of Physicians, the following gentlemen satisfied the Examiners;—

Mr. O. Edwards, M.R.C.S.
,, D. H. Forty, M.R.C.S.
,, J. Hobson.
,, W. H. Lamb
,, W. J. Tyson, M.R.C.S.
,, A. K. Newman.
,, F. A. Mahomed.

The papers will be given as space permits.

APOTHECARIES' HALL.

At the Hall on the 21st inst., the following gentlemen passed their final examination:—

Mr. Webb.
,, W. C. James.

The Wards.

MEDICAL.

The following Cases were admitted between Oct. 22 and Oct. 28.

ADDISON—No admissions.

MARY.—7—Colic. 10—Convalescence after rheumatism. 12—Phthisis (?) Pneumo-hydrothorax. 19—Rheumatism, sub-acute.

MIRIAM.—18—Coma—albuminuria. 21—Chorea. 26—Pleuro-pneumonia.

STEPHEN.—2—Acute rheumatism. 6—Abscess in cheek. 12—Eczema rubrum. 21—Pleuro-pneumonia. 39—Cardiac. 43—Acute rheumatism. 44—Psoriasis. 49—Chronic Bright's disease. 50—Acute rheumatism.

JOHN.—3—Cardiac dropsy. 12—Malaria—typhoid. Right 14—hemiplegia aphasia—syphilis.

PHILIP.—8—Ascites and anasarca. 9—Rheumatic fever. 12—Enterica. 13—Renal calculus. 21—Paraplegia. 30—Facial erysipelas. 32—Lumbago. 35—Diabetes. 6—Enterica. 42—Periborsitis. 46—Diabetes. 47—Rheumatic fever.

ADDISON.—3—Mitral stenosis. 4—Pneumonia. 7—Phthisis. 8—Rheumatic fever. 18—Progressive muscular atrophy. 17—Rheumatic fever.

BRIGHT.—6—Ulcerating endocarditis. 7—Pneumothorax. 8—Pyæmia. 11—Enterica 14—Sinapidermatitis. 16—Bronchitis. 23—Diphtheria.

SURGICAL.

The following Cases were admitted between Oct. 22 and Oct. 29.

CHARITY.—1—Spurious anchylosis of joints of hand. 10—Inflamed bursa patellæ. 17—Recurrent fibroid on nose. Necrosis of femur.

MARTHA.—5—Stricture of œsophagus—hysterical. 7½(cot)—Morbus coxæ. 11—Synovitis of ankle. 16—Œdema of foot, 18½ (cot) Scald. 19—Mammary abscess. 22—Carbuncle.

LAZARUS.—1—Synovitis of knee. 6—Fistula in ano. 12—Contused foot. 16—Contracted knee.

JOB.—2—Exostosis from tibia. 4—Synovitis of knee. 7—Morbus coxæ—abscess 20—Ununited fracture of tibia and fibula. 23—Tumour of inferior maxilla.

NAAMAN.—1—Fistula in ano. 3—Stricture of rectum. 4—Contused wound in arm. 11—Stricture of urethra. 12—Tumour in frontal region. 13—Stricture of urethra. 16—Necrosis of tibia. 19—Old dislocation of both humeri, unreduced, &c.

DORCAS.—4—Recurrent malignant growth in glands of axilla, after excision of breast. 14—Elephantiasis of leg. 18—Contused wound of scalp. 19—Enlarged bursa patellæ. 22—Morbus coxæ. 27—Fractured tibia.

LUKE.—1—Synovitis of knee.

CORNELIUS.—3—Laceration of hand, with fractured metacarpal bones. 5—Fractured superior maxilla. 8—Lacerated wounds of face. 9—Fractured femur. 13—Injury to back. 14—Fractured fibula—ruptured intestine—peritonitis,—Death

ACCIDENT.—2—Compound fracture of tibia and fibula, amputation. 3—Separation of lower epiphysis of tibia and fibula. 10—Fractured fibula. 27—Injury to back.

LYDIA.—No admission.

BIRTHS.

On the 20th inst., at Brook Street, Grosvenor Square, the wife of Thomas Bryant, F.R.C.S., of a daughter.

On the 20th inst., at Guy's Hospital, the wife of J. C. Steele, M.D., of a son.

ANSWERS TO CORRESPONDENTS.

A letter from "Dens" will appear in our next.

The Editors acknowledge, with thanks, the following honorary subscriptions from the Treasurer and Members of the Staff:—The Treasuror, £1 1s.; Dr. Owen Rees, £2 2s.; Dr. Habershon, £1 1s.; Dr. Wilks, £1; Dr. Pavy, £1 1s.; Dr. Moxon, £1 1s.; Mr. Cooper Forster, £1 1s.; Mr. Bryant, £1 1s.; Mr. Howse, £1 1s.; Mr. R. Clement Lucas, £1 1s.

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A number of Subscriptions for back copies of the GAZETTE are still owing. Gentlemen will oblige by paying the same to the Editors or Mr. H. WILLIAMS, Hospital Accountant, Post Office Orders being made payable at the Borough Post Office. Payment by HALFPENNY Postage Stamps will be accepted.

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AS the time for the College Examination is getting near, a few words of advice may be useful to those who are about to present themselves. We have noticed, that men preparing for an examination have been accustomed to spend the time previous to the ordeal solely in reading books, which treat of the subjects on which they will be examined. Early idleness is the only excuse for this, and did men accustom themselves habitually to go round the wards, and remember the facts they learn there, using their books only to explain and elaborate matters, the Court of Examiners would be approached by fewer aching hearts. For example, Surgery is eminently practical, and cannot be learnt like the pure sciences, from theoretical treatises only. Eczema could not be diagnosed from knowledge gained by mere reading, and nothing but practice can teach us to set a broken bone. Men persuade themselves that a minute knowledge of subjects is required, and so in cramming up the minutiæ they lose sight of the general principle. If one case be carefully impressed on the mind, there will be a clearer knowledge of the disease, and not only clearer but more available both in the examination-room and at the bedside, than the largest amount of learning gained only from books. Let each one think and take as an example a disease which he has read about, but of which he has not seen a case, and ask himself if he could be trusted to diagnose the disease, and distinguish it from others which most closely resemble it. We anticipate the answer—they could not. Can, then, a preparation from books be a *sound* preparation for an examination? It may be all very well to say that cases illustrating the disease have been seen, and that books only are read to impress the facts and teach the details which can only be learnt in that way, but we still think that if men leaned their success at an examination on what they have seen and felt, rather than on what they have read, they would have a firmer foundation for hope than is now usual for men to carry with them into the room.

Some Examiners, too, have an awkward habit of asking long rambling questions. Sometimes the beginning is forgotten by the student before he has heard the end, and frequently the purport of the whole is not understood. This is easily overcome by asking for a repetition of the question, when probably it is put in a more condensed form. Those examiners are least to be feared who have amongst students the worst name, for, as a rule, their questions are plain and staightforward, and can only admit of a definite answer. Let every man be assured that if he be well prepared in his subject, those examiners are the the best who require a plain answer to a plain question, and an answer that smacks of the wards rather than of his books. But these are those who find out a man's worth, and reject him if unsuitable.

Lectures on Midwifery.

By J. BRAXTON HICKS, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

LECTURE II.

MECHANISM OF LABOUR.—The movements of the fœtal

head, or the mode by which it makes its transit through the pelvis depends upon (1) the motive force and (2) the obstacles that oppose its progress. The motive forces are the uterus, the abdominal muscles, and a slight impulse derived from the vagina. The obstacles are the uterus, the os uteri more particularly, the vagina, the vulva, and the bony walls of the pelvis.

It used to be considered that the head presents at the brim, with its longitudinal diameter in the antero-posterior diameter of the pelvis, but it was not until lately that the oblique position of the head was discovered by Sir Fielding Oulde, and subsequently Nagle set the matter at rest by his accurate observations. The head in its descent usually goes through a series of movements, but there are cases in which the ordinary rule is not observed. Indeed if the head be small, and the pelvis excessively large, the uterus and its contents gravitate towards the outlet and remain there during the whole of labour, so that the os although closed may be felt just within the vulva with the finger. But in cases where the head and the pelvis are of average size, we find the head chiefly present at the brim with its longitudinal diameter in the oblique and not in antero-posterior diameter. There is what is called a "right oblique" and a "left oblique" diameter. In giving these names, right and left, we are guided by the position of the head with regard to the sacro-iliac synchondroses. In the "right oblique" the head lies between the right sacro-iliac synchondrosis and the left acetabulum: in the "left oblique" between the left sacro-iliac synchondrosis and the right acetabulum. These are not the terms used by Dr. Hicks as they may give rise to confusion, but as they are frequently made use of in books it is necessary they should be understood.

There is a difference between the presentation and position of a child. The presentation is that part which presents itself, but the way in which the presenting part lies is called the position. The "presenting part" is a term applied to the part which presents in the axis of the parturient passage. Though there is some laxity in its use, it being often used to mean the part felt through os uteri; but as this is something not in its natural position, it is best to use it in the sense just mentioned.

The head, then, appears at the brim in one of the oblique diameters, that is to say, the long diameter of the head is lying obliquely across the pelvis with the face either forwards or backwards. The head has also been generally believed to have another indication: for, as the fundus uteri falls forwards, therefore the presenting most anterior part is most dependent. Therefore the bi-parietal axis does not coincide with the plane of the brim, but its anterior limb inclines downward and forward. This inclination has, howsver, been called in question, and Dr. Hicks is inclined to think that this anterior dip has been exaggerated.

The fœtal head on entering the pelvis may take one of four positions; these are divided into two classes, two in which the occiput is forwards, two in which it is backwards. It matters very little indeed whether the occiput is inclined to the right or left, but it makes a great difference in the ease with which labour is accompanied whether the occiput be to the front or back. The labours are easiest where the occiput lies forwards, they are difficult generally when it lies backwards.

The *first* position, where the occiput is towards the left acetabulum is called the "left occipito-anterior." The *second* position where it lies to the right acetabulum is called the "right occipito-posterior." The *third* position, where the forehead is to the front, and the occiput against the right sacro-iliac synchondrosis is called the "right occipito-posterior." The *fourth* position, where the occiput is against the left sacro-iliac synchondrosis is called the "left occipito-posterior." The first position is the most common, and occurs in 75 per cent. of cases; the next most common is the third, this occurs in 23 per cent. of cases; a few cases of the second and fourth position complete the hundred.

The head in traversing the pelvis, of course, descends *en masse*. The centre of the child's head would be, more or less, coincident with the axis of the parturient canal through which it is passing. The usual movements which the head makes in its descent are these:—1. Obliquity. 2. Flexion. 3. Rotation. 4. Extension. 5. Restitution.

Obliquity.—Before the pains have begun the child's head does not lie in any definite position, but after the uterus begins to contract, it sets towards the brim, for the easy and light pains force the head into the funnel-shaped pelvis, in the most easy direction for it to descend. If the pelvis be abnormal the position will be also abnormal: but the position will always be normal with regard to the individual pelvis through which it is passing; that is to say, the long diameter of the head will lie in the long diameter of the pelvis. *Obliquity*, then, is the movement by which the head fits itself into one of the oblique diameters of the pelvis, the occiput either being forwards or backwards.

The next movement is *Flexion*, namely, the bending of the neck, so that the chin of the child is brought into contact with its chest, this movement is effected by the impingement of the head on the brim; for the neck being inserted posterior to the centre of the base, the pressure from above necessarily produces this movement, and by it the vertex is thus made to present.

The head descends in this position, namely vertex-presenting, till the parietal bones reach the spine of the ischium and its ligaments; by contact with this obstacle the occiput is guided towards the symphisis pubis, so that this comes in contact with the left descending ramus of the pubes; and thus is accomplished the movement called "Rotation." The extent of this movement in this, the first portion, is therefore nearly an eighth of a circle.

About this time the movement called "Extension" begins to occur. For, as the uterine force directs the child downwards and backwards the head comes in contact with the curve of the sacrum, which therefore deflects its direction, and thus the part in contact, namely, the forehead, glides down the concavity, while the occiput curves round the pubic bone, being kept in close contact with it by the counter resistance of the sacrum. Of course the occiput also descends but to a less extent, than the forehead, and that by so much as the depth of the pubes differs from the depth of the sacrum and coccyx.

So far the bony part only of the parturient passage has been described; but the soft parts now become engaged, for as the forehead descends below the coccyx it presses against the posterior wall of the vagina, supported by the rectum and the perinæum, which, although they yield and stretch sufficiently to allow the head to descend, yet they are sufficiently resisting to continue the deflexion, and to push the whole descending mass forward. Thus the occiput having emerged from beneath the pubic arch, the tension somewhat releases, and the forehead, eyes, nose, mouth, and chin of the infant successively pass over the edge of the outstretched perinæum, and thus the delivery

of the head is accomplished. A further movement of the head yet takes place, the account of which will follow in our next issue.

Clinical Lectures.

ON SYNOVITIS OF THE KNEE JOINT.

By J. Cooper Forster, M.B., F.R.C.S.

(Surgeon to, and Lecturer on Surgery at, the Hospital.)

Mr. Forster began his lecture by reading the report of two cases of Synovitis, one being acute and the other sub-acute. The former occurred in a man 25 years of age. There was no history of rheumatism or gout, but three years back he had a sore on his penis, followed by a suppurating bubo, and eighteen months since he had gonorrhœa. On Sunday, Oct. 11th, he fell while wheeling a barrow, the barrow falling on his knee and hurting him; he took no notice of this, but felt pain during his work on the Thursday, and came to the hospital the next morning.

On admission, the right knee is much swollen, especially at the upper and inner part. Fluctuation is distinctly felt all over the joint; there is heat and redness over the joint, and it is very tender. The patient has a long back-splint on, and ice applied to the part.

Oct. 19th.—The swelling has gone down considerably, the heat has disappeared, and the part is not so tender.

Oct. 25th.—Patient has had the ice-bag removed.

Oct. 27th.—The skin feels a little warmer, but the swelling is less.

Oct. 28th.—Fluctuation still present. All heat and redness has disappeared.

The second case. A man, aged 31 years, admitted Oct. 19th. Patient has always been subject to gout and rheumatism.

Pain and swelling have been in left knee-joint on and off for the last eighteen months, the swelling being chiefly at the upper part. Up to July he had been able to follow his usual occupation without great difficulty, but since that time he has not done much.

In August he was struck by a ball upon his left knee, the joint swelled considerably and was painful, he did not rest it, but got about on crutches.

On admission, the left knee is much swollen, and the outline of the joint lost; distinct fluctuation is present, also heat and redness over the skin.

The same treatment was adopted in this case as in the former one.

Oct. 24th.—Patient seems much better, the swelling has subsided.

Oct. 27th.—A good deal of thickening is still present, and fluctuation still plainly felt.

Remarks.—These two cases are quite distinct from each other, the one being an acute synovitis, the other sub-acute. The former occured as a result of the blow, and inflammation of the synovial membrane soon followed, but it is doubtful whether the blow had anything to do with the latter case.

In one case the patient, like a wise man, comes immediately to the hospital, and is treated promptly, whereas in the other case the man continues to get about, and, of course, speedy relief does not follow as in the former case; nay, impairment of the joint may happen, possibly disorganization.

Treatment.—This is very important. Always apply a back splint, as not only does it keep the knee quiet, but, in case of ankylosis occurring, the knee being straight is in the best position that it can be for after life. Unless you put on a splint, the patient is sure to bend the joint, and thus get it into a bad position. Both these cases were treated similarly, and the acute case, on account of its early treatment, got well quickly; whereas in the second there will be a tardy recovery. Thus it is very important that, even in slight cases, the joint should be kept perfectly quiet; if not, the synovitis goes from bad to worse, as in the second case, and the recovery will be much retarded. No medicines were given, as they were not required. A short splint is no good, as it does not properly fix the joint. Ice is now generally used, although this was not thought of, years ago. A substitute for it was common spirit lotion; this answers very well, but as it so quickly evaporates, it must be constantly renewed, and consequently a vigilant eye must be kept on those who attend to the patient. Ice, with two exceptions, viz., old people and young children, does good. Warm applications will be more comfortable and useful in old people and young children. The ice may be continued for some days, but I have seen a slough produced by its application, when the constitution has been impaired and the vessels bad. There is an immense number of vessels supplying the knee-joint, and so, when inflammation appears, there will be a large quantity of blood present, and consequently an increase of temperature. In the acute case, these have all disappeared, and the patient is well, but is he to get about directly? No! keep him quiet for another week, in order that the tissues may return to their natural state. The general treatment you should always adopt in all injuries connected with joints, is to keep the joint at rest for a few days after the inflammation has subsided. You will have to be firm with your patient or the limb may lapse into the condition seen in the second case.

Reports of Cases.

CASES OF PLEURISY TREATED BY STRAPPING THE CHEST.

Reported by Mr. H. Williams.

The following cases may be useful in confirming Dr. Roberts's opinion of the great benefit which is derived in pleurisy from firmly strapping the affected side of the chest.

No. 4, Addison. Admitted Oct. 21st, in the evening, with right pleuro-pneumonia. She complained of sharp catching pain in right side below the nipple, her respiration was irregular and distressed, 70 in the minute. Loud pleuritic rub to be heard. The whole of the right side was firmly strapped at the moments of deep expiration. On the morning of Oct. 22nd she says the pain in her side is much less since the strapping, to use her own words "I think that's what's saved me, I don't think I could have gone on." The pain has returned at times when the plaister has become loose, but ceased again on the renewal of the strapping. She says it is the only thing which has done her side good.

No. 7, Addison. Re-admitted Oct. 26th, with phthisis,

after having been out of the hospital a month. During her first stay in the hospital she had left pleuritis with audible friction sounds, and for this the side was tightly strapped with much relief to the pain. Some difficulty arose in making the plaister stick, so Mr. Coley, the ward-clerk, moulded a gutta-percha splint to her left chest, she was so much relieved that she soon left the hospital. She wore the splint constantly at home and kept free from pain until the night of Oct. 23rd, when she woke up with very bad pain at the old spot. The pain continued until her re-admission. No strapping was put on for four days, the pain meantime keeping just as severe. On Oct. 30th the whole of the left chest was again secured. To-day, Nov. 1st, she says the relief given by the strapping was almost immediate, hardly any pain now, and she feels ready to sit up.

No. 35, Addison. Admitted Oct. 14th, with right pleuritic effusion as high as scapula, with friction sound at upper margin of fluid, and much pain. Strapping applied Oct. 22nd. She reports that the strapping eased her pain, and "held her together when she coughed;" it came off Oct. 30th, since which time her chest has not been so comfortable.

No. 20, Mary. Admitted Sept. 29th, with acute rheumatism (fourth attack) and pericarditis. She had been ill fourteen days. In the evening of Oct. 2nd the House Physician was called to see her, and found her respiration short, rapid, and irregular, with sharp inspiratory cries at times; she had acute pain about the angle of the right scapula; resp. 68. Pleuritic rub over seat of pain. Six leeches applied without relief; they were repeated next morning. After the bleeding from them had ceased, the right chest was firmly strapped with pieces of plaister four inches wide. Next morning she says she feels easy, she passed a very good night, whereas the night before she never closed her eyes. The strapping kept on a week; there was no need for its removal.

No 22, Bright. Admitted Oct. 31st, with acute rheumatism. In the evening she complains of intense pain below the left nipple, catching her breath, and compelling her to cry out now and then. There is a sharp, double pleuritic rub, to be heard below and outside nipple. She says the pain only began as she was coming to the hospital in a cab. Strapping was applied in the usual way at 10 p.m. At 2 a.m. she says she is very comfortable, pain not gone, but very much better. She has been to sleep. On Nov. 1st, side still continues easy.

These cases, I think, need no comment. They speak well for themselves.

Obstetrics.

The case of retroflexion of the pregnant uterus, reported in the *Gazette* for the 17th ult., has left the hospital well. The uterus, after its restoration, kept well in place, and could be felt reaching nearly to the umbilicus. The bladder (over which the patient had no control) regained its power in a few days, and the cystitis and albumen rapidly disappeared.

On the 3rd inst., the Charity were called to a hand presentation. It was found to be the right hand, the back being anterior. Patient had been in labour several hours, and the membranes had ruptured, but the pulse was good. When fully under the influence of chloroform Dr. Galabin introduced his hand into the uterus, and, having seized the left foot, brought it down, so that the half-breach presented. The cure was then left to nature, and a dead fœtus was expelled within an hour.

The same day, the long forceps were applied in a case of tedious labour. The patient had always had quick times with her fifteen other children, but in this case she had been three days in labour (the membranes having ruptured on the second day) and was becoming exhausted; pulse 140. The head was in the first position, resting on the brim, and appeared abnormally large and ossified. After half an hour's traction the head was delivered. The usual difficulty is then usually over, but in this case it had commenced, for it seemed impossible to get the shoulders delivered. Hoping the child might still live, it was deemed inadvisable to exert strong traction on the head, but the fore-finger was passed into the posterior axilla (the right) and an attempt made to draw down that shoulder, but unsuccessfully. Pressure was now tried above the pubes to push off the left shoulder, which appeared to be resting on that bone. This, too, was useless. After various other attempts, a thin cloth was passed round the shoulders. This answered well; for a few minutes sufficed to deliver that shoulder, and the other soon followed. The child was still-born. Patient then began to flood, and the Junior was obliged to detach and remove the placenta. The hæmorrhage then ceased, and uterus contracted firmly, but patient was much exhausted; pulse 150-60, and it was necessary to use stimulants freely for the following twenty-four hours. She is now much improved, but still very weak.

The Dissecting-room.

In our last report we mentioned that there had been a lull in the supply of Subjects. A few days later, as if the Inspector of Anatomy had received a copy of our *Gazette*, there arrived an unusual number of bodies—no less than six having been delivered on one day. Since the commencement of the session twenty-five bodies have been received, which are equivalent to two hundred "parts," so that every student of the first and second years ought by this time to have received his first "part," and many must have commenced dissecting a second.

The instruction of first year's men has been somewhat differently arranged this session. Instead of demonstrations on the bones, a system of class-teaching has been instituted. The fresh-men have been divided into four classes, each containing about twenty students. Mr. Golding Bird meets one of his classes on Thursdays, at 1·30, and the other on Saturdays at 10 a.m. Mr. Jacobson's days are Mondays and Wednesdays at 1·30.

We understand that four gentlemen will present themselves for the First College to-day.

THE PHYSICAL SOCIETY.—The third meeting of this society will be held in the Chemical Theatre, at 7.30 this evening, when Mr. Clarke will be in the chair, and Mr. Jumeaux will read a paper on "Talipes, or Club-foot."

THE THOUGHTS OF THE HEART.

There was one really interesting result of the skilfully-conducted examination of the body of Napoleon III. which excited no apparent surprise in the physicians and pathologists engaged in that melancholy task, and which, in their report, they cast in such cold technical terms that it passed as a thing of no signification whatever. It ran thus: "*The brain and its membranes were in a perfectly natural state.*" I cannot quite say what one would have expected in that brain, but pathology makes keen observers; nevertheless it seems no signs of broken empire or lost legions were discovered. Yet microscopes are very strong now-a-days, I doubt though if they were used at all on the occasion in question, perhaps that is as well; spying into the brain with the highest object-glasses is something like using extra big spectacles to examine the closed edges of a book you are wanting to read but cannot open.

"Perfectly natural state." Truly what insight pathology gives then! who that has to deal with brain-miseries would not be a pathologist! But why speak thus of pathology when maybe the question is out of her compass. Sciences obtain what powers they have, by ignoring all points in real things except those which the particular science elects to include in her system, and those points are not usually the ones by which individual things address our personal tastes and feelings. Thus botany sees our luscious "British Queen" as merely *Fragaria Vesca*, like a common wild strawberry, because she has settled already what she will admit in strawberries, and does not take them with cream. Is it, then, in the same way that pathology is quite content to see nothing in a fallen Emperor's brain, because she has settled already what she will see in brains, and looking for broken empire and lost legions is out of her line? or is it that *the peculiarities that create and lose empire don't belong to the brain at all*?

Napoleon I., we believe said that the world is governed by a good stomach, and as he broke to pieces and set up more governments than any other authority he may be supposed to know. No doubt brains are wanted, but a higher necessity than the requirement of brains is the need of appetite to arouse and strength to support the work of a good brain. When Queen Mary said Calais would be found written on her heart, she spoke, in her way, better physiology than any one would hold who directed the search of her brain.

The physiologists persuade you that thoughts come from the brain, and talk of its activity, discharges of nervous force, &c. But don't take that as the whole truth. The fact is the brain is a sort of Æolian instrument of many strings, whereupon the several organs play ("organs play" sounds as topsy-turvy as Polonius at supper where he was being eaten, but I cannot help it). There are no thoughts in the brain without the whirl of the blood through it, any more than there is music in an Æolian harp when the air is still; and the brain in its vast complex receives influences which stir it to action in various regions and manners according to the appetites and passions connected with the several functionary parts of the body. So that David was right when he said "The thoughts of his heart," but the heart is not the only agent for eliciting thoughts from the brain; for while we say "out of the fulness of the heart" in reference to some; yet in other cases you feel sure you would be more right in saying "out of the fulness of the stomach the mouth speaketh," or else out of an over-full muscular development of the testis, &c. In support of this, remember how the thoughts of a bull are plainly from his horns, of a horse from his heels, of a polecat from her perfume bag, &c. In short, the demand to be used creates the supply of employment both in the body corporal and in the body politic.

Now, practically, you see what a responsibility there is in having any organ over active, hypertrophying beyond its just proportions, and hence playing too vigorous a tune on the nervous stringed instrument in your cranium, and how one must watch the energies of a dominant organ and withdraw from circumstances that rouse its too great activity. But it is not only in regard of individual organs that this is true, the danger of getting only thoughts of one sort, or too much of one sort extends to a much higher sphere of activity. For instance, if you spend all your time in experimental processes of scientific weighing and measuring, you will come at last to think all nature is to be explained by the ponderable and measurable, as Professor Tyndall appears to have done. On the other hand, if you employ your time in the over activity of the organization at play in religious emotion; that kind of emotion will determine the turn of your thoughts until you are ready to oppose the conception of order in Nature in which religious liberty and tolerance are grounded, as many of his opponents do.

In short, special kinds of activity determine special ways of thinking, in other words determine character. Thus are we creatures of our own thoughts, and he who has no special activity will have no character.

PILOCEREUS SENILIS.

Operations.

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TUESDAY, NOV. 3RD.

Mr. Bryant had a case of exostosis from the upper end of the tibia. He made a longitudinal excision, divided and turned back the adherent tissues, and with mallet, chisel and elevator, removed the growth. On section it was found to be a true exostosis, with a little cartilage over its lower end, and not pedunculated. Previous to removal it had the appearance of a growth expanding the bone.

Mr. Bryant also removed a myeloid tumour involving the anterior portion of the inferior maxilla. A semi-lunar incision was made one and a-half inches on either side of the symphisis along the lower margin of the jaw, and the tumour dissected out posteriorly. A chain saw was now applied, and the jaw divided on either side. The muscles connecting the tongue with the symphisis and outer portion of the jaw being now divided, the tumour was removed through the incision along the chin. Hæmorrhage was restrained by torsion; sutures, and a strapped pad of lint applied. On section the tumour was found to have invaded the bone, no shell of bone remaining anteriorly, but merely the periosteum—a shell posteriorly and inferiorly—microscopically it had all the appearances of a myeloid formation. The growth, which had apparently been caused by a blow nine weeks ago, was quite central, extending half an inch on either side of the median line. Speech and tongue-movements only slightly interfered with. Three weeks ago the swelling had been opened by a surgeon, but nothing but blood had flowed. Several teeth had been loosened or extracted on account of the growth.

OPHTHALMIC DEPARTMENT.

FRIDAY, OCT. 23RD.

Mr. Bader's first operation was removal of cataract in an old man. This he did by extraction, making the usual incision downwards by means of his new curved knife, which enters the cornea on its inner or nasal side. No chloroform was administered, and the lens capsule slipped out very readily.

After this there were two iridectomies, both for closed pupils.

The next case was a boy about ten years of age with double entropion of the lower lids. Mr. Bader having first cut out a narrow strip of skin and muscle close to the free margin of the lower lids, removed a wedge-shaped piece of cartilage from the bottom of the wound, and brought the margins together by a suture.

There was next a very interesting and somewhat rare operation for divergent strabismus. Mr. Bader first divided the conjunctiva, sub-conjunctival fascia, and tendon of the external rectus, so as to free the eye completely on the outer side. He then divided the conjunctiva freely on the inner side, and having divided the tendon of the internal rectus, stitched the end of the tendon which remained attached to the muscle to the conjunctiva and fascia nearer the cornea. Both eyes were operated on in the same manner, and were afterwards ordered to be kept bound up with wet lint. After this there was one more iridectomy, and also another extraction of cataract, for which chloroform was administered.

MONDAY, OCT. 26TH.

Mr. Higgens had several interesting operations.

The first was a case of severe entropion of both lids. Mr. Higgens had operated on one eye a fortnight before with complete success, there being not even a scar remaining. He now proceeded to operate upon the other in the same manner, viz., by removing a long narrow strip of skin and muscle from close to the margin of the lower lid, and then leaving the wound to granulate up.

He next operated upon a case of squint; dividing the tendon of the internal rectus in both eyes, the patient being partially under the influence of chloroform.

The next was a case of cataract in an old man aged 78. Mr. Higgens made the usual incisions downwards, entering the knife at the outer margin of the cornea. He then removed a portion of iris because the pupil was rigid, and having done this attempted to extract the cataract; but, owing to the large size of the latter, he had to enlarge the corneal wound with scissors, and it then slipped out.

The last operation was removal of a soft cataract in a young man by means of suction. Bichloride of methylene having been administered, a small corneal incision was first made with an iridectomy knife, a sharp hook was next inserted, and the lens capsule freely lacerated. Then the suction tube being inserted, nearly the whole of the cataract was sucked out, the remainder being left to become absorbed.

Post-mortem Room.

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There was an interesting case on Monday, October 26th, which had been under Dr. Moxon's care, and in which phthisis, ulceration of the intestine, and sacro-iliac disease were all present, but the symptoms and conditions during life were not sufficient to afford positive proof of the existence of these maladies. The diagnosis of obscure internal tubercular disease made during life, was founded on the chronic course of the complaint with irregular mild pyrexia and great wasting, and without any sufficient cause discoverable. The absence of physical signs was due to the patient's weakness and to great pain in the left hypochondrium, which caused him to breathe shallow, but chiefly to the dry state of the bronchial tubes, no sputa and no rales being present; the dryness itself being perhaps connected with the diarrhœa he suffered. He himself always spoke well of his chest as free from disorder.

Upon examining the lungs, grey tubercle was found distributed throughout, but was more marked in the upper lobes. In the lower lobes the tubercles, although numerous, were well surrounded by healthy lung tissue, while in the upper lobes there was evidence of local pneumonia, especially at the right apex. There were two cavities on the right side and one on the left at the apex, while old and extensive pleuritic adhesions existed on the left side. These conditions did not, however, give rise to more than very slight bronchophony and bronchial-breathing just below the right clavicle. This was over a very superficial cavity into which a tube could be distinctly traced. For some weeks no sputa were expectorated, until the last fortnight, when this came in large quantities, and pus was found in the tubes after death.

The case plainly shows that extensive but scattered deposits of tubercle, when surrounded by a fair amount of healthy tissue, may give no certain auscultatory signs, and even a cavity of the size of a chesnut may give little evidence of its existence during life.

The kidneys exhibited a somewhat granular surface on stripping off the rather adherent capsule. The cortex was decidedly deficient in some places, but there was no evidence of lardaceous disease.

Spleen.—Large, not lardaceous.

Liver.—Large, tough, but not showing any amyloid deposit with iodine.

Intestines.—In the lower part of the small intestine and the greater part of the colon the mucous membrane was dotted over with small scattered ulcers. At the cœcum and in the rectum larger irregular ulcers were found, apparently formed by the running together of the small ones, the mucous membrane between being raised and infected. No tubercles were observed. The patient had come from Southern Russia, and the symptoms, as well as the history, at first suggested dysentery; thus there had been considerable diarrhœa, but the dejecta were on several occasions searched for sloughs and blood and mucous with no success; so that the absence of the latter in clinical observations is not sufficient to exclude the possibilities of ulcers existing, but if the ulceration had been dysenteric, mucous or blood would probably have been discovered.

The patient had experienced considerable pain about the hip, and down the thigh and leg of the left side; percussion over the trochanter or against the sole of the foot gave rise to intense pain. This condition became suddenly relieved three weeks before death. Mr Howse examined him, and considered that while it was quite possible for sacro-iliac disease to be indicated by these symptoms, yet they might be due only to neuralgia. An abscess was found outside the anterior ligament of the articulation, so that it is probable that pus was at first confined by the ligament, but afterwards burst out of the articulation and thus relieved the tension and the pain.

There was also a case of diphtheria on the same day from Bright ward, under Dr. Moxon's care, formerly a patient in Dorcas ward, under Mr. Durham, for talipes equino-varus. The patient had been ailing one week, her throat was sore, voice husky, tonsils sloughy, and she could only swallow fluids. A false membrane was removed from the tonsils a day or two before death, but was renewed the next morning. About the same time a cast of the trachea was expectorated. Temperature not high, urine albuminous, breathing good to the last. At the autopsy the tonsils were in a sloughing condition, but there was no false membrane over them. There were ulcerations about the vocal cords, and just below were some slight deposits of lymph. Extensive broncho-pneumonia existed. It was also interesting to observe that neither adhesion nor cicatrix remained to record the fact that the tendo-achillis, and the tendons of the tibialis posticus and flexor longus pollicis had been divided. There was a portion of the divided tendo-achillis which resembled new-formed tissue, but there was no line of demarcation between the new and old.

ROYAL COLLEGE OF PHYSICIANS.

At a recent examination for the Membership of the Royal College of Physicians, A. K. Newman, M.B., and Mr. F. A.

Mahomed satisfied the examiners. These names were included last week, by a mistake of the printer, in the list of gentlemen who had passed the examination for the Li cence.

The following papers were set at the last Examination for the Licence :—

Materia Medica and Chemistry.

1. Describe the action of chloroform and chloral hydrate, in both medicinal and poisonous doses What precautions are needed in inducing chloroform narcosis; and what conditions, either of positive disease, or of predisposition thereto, contraindicate the free use of these remedies?

2. Give the "characters and tests" of the fluid preparations of arsenic. In what diseases is this remedy beneficial? What symptoms and effects may be expected to arise from free or prolonged use of its preparations?

3. How is hydrocyanic acid prepared? Explain its formation by the process you would employ. How may the presence of the acid be detected in an organic mixture?

4. How may albumen be detected in urine? State the precautions which must be adopted in testing urine for albumen.

Midwifery and the Diseases of Women.

1. How would you treat a case of difficult labour where, upon your arrival, you found the hand of the fœtus external to the vulva of the mother?

2. What are the disadvantages of retroflexion of the uterus?

3. In a pelvis measuring at the brim little over three inches in diameter, the head of the child presenting, and considerable delay thereby caused in the labour, what methods of treatment have been recommended? State which you would adopt.

4. What are the symptoms of pelvic cellulitis, local and general; and how do such cases generally terminate?

Medical Anatomy and the Principles and Practice of Medicine.

1. How is ague to be distinguished from hectic and suppurative fever? Enumerate its varieties.

2. Describe the various morbid conditions which may give rise to Hæmoptysis? State how you would distinguish those conditions from each other, and give a short account of their treatment.

3. Describe the anatomical position of the liver in relation to the adjacent organs, and to the walls of the chest and abdomen.

4. Give a clinical history of a case of chorea, embracing its origin, complications, and treatment.

5. What are the indications afforded by the thermometer in enteric fever, typhus fever, pneumonia, pleurisy, and phthisis?

6. What are the causes of white softening of the brain? Explain its symptoms, and the grounds on which you would base your diagnosis.

Correspondence.

To the Editors.

SIRS,—Having read the article on the desirability of giving us opportunities of studying affections of the nervous system, I wish I could draw the attention of the authorities to another special department which receives in several London hospitals a due amount of regard, but which is much neglected here. I refer to the dental department.

During the last six months I have extracted some hundreds of teeth among the out-patients, and have seen at least a thousand others undergoing decay.

One can only advise a patient to go to the Dental Hospital, Leicester-square, or come and have them taken out when they ache. I will say nothing of the value of these members or of the distress caused by their loss; it is fully treated of in the text-books.

Mr. Savory, when opening the present session of the above institution, said, "The full advantage of your useful art is no longer confined to those with ample means, but is given freely—as all such blessings should be—to the poor." There are crowds of poor around this hospital who are quite unable to pay the most moderate charges of a dentist to have their teeth properly attended to, and there is not an institution in all Surrey where it is done gratuitously; yet the hands of our able dental surgeons, and of several students desiring opportunities for practising the valuable art of 'stopping,' are tied by the lack of a small outlay by the authorities. Messrs. Salter and Moon do treat irregularities of the teeth, but the expense to the hospital of putting two or three teeth straight, for the sake of good looks, is, in some cases, sufficient to cover that of saving fifty teeth by filling.

I believe an adequate outlay in this department would be amply repaid by the attendance of men desiring the dental diploma of the College. There are some here now who attend other places for instructions in surgical dentistry.

I hope the subject will receive the attention of those in office, for the sake of suffering humanity, if not for ours.

DENS.

"An Exeter man" writes to assure us that it was not through Mr. Bankart's influence that all the Exeter students came to Guy's this session, but that they exercised their free choice in the matter, and chose the school they considered afforded the best opportunities for study. He mentions Mr. Domville, the House Surgeon, who, as a Guy's man, upholds on every occasion the glory and honour of his old school.

SURGICAL WARDS.

The following Cases were admitted between Oct. 29 and Nov. 4.

DORCAS.—4—Polypus. 15—Carcinoma mammæ. 18—Ectropian vesicæ.

LYDIA.—3—Varicose veins. 12—Lipoma. 21—Talipes varus. 23—Œdema of leg.

MARTHA.—3—Ulcer of leg. 5—Fracture of lower jaw. 14—Poisoned wound, diffuse inflammation. 16—Œdema of leg.

ACCIDENT.—2—Crushed leg, amputation. 5—Crushed foot, Syme's amputation. 6—Compound fracture of right leg, injury to left ankle, back, and scalp. 11—Pott's fracture. 20—Fractured spine. 21—Crushed foot. 30—Fractured patella.—32—Concussions.

LUKE.—1—Dislocation of knee joint. 10—Stricture. 16—Chronic Synovitis. 17—Dislocation of knee joint.

CHARITY.—Bursitis patella. 10—Contraction of knee. 11—Lymphadenoma. 13—Rheumatic arthritis. 14—Hip disease. 23—Osfitis of femur.

LAZARUS.—6—Fistula in ano. 8—Periostitis. 12—Injury to foot. 13—Absorbent inflammation of arm. 14—Absorbent inflammation of arm. 16—Injury to leg.

JOB.—2—Exostosis. 23—Myeloid of lower jaw. 24—Abscess in groin.

NAAMAN.—4—Chronic Synovitis.

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WE publish, in another column, a list which has been prepared by the Secretaries of the Physical Society, giving the names of all the gentlemen who intend to read papers before the Society during the present Session, together with the titles of their subjects. This list has been placed in the hands of members, and will have the effect, we doubt not, of inducing them to carefully read up the subjects beforehand, so as to improve the character of the debates. It will also have the important effect of relieving the minds of Secretaries and Presidents concerning the procuring of papers, which has sometimes in former Sessions been a matter of no small difficulty. It has, in fact, happened more than once in our recollection, that an unfortunate President has been called upon, at the notice of forty-eight hours, to read a paper for which he was totally unprepared, and even if a volunteer has been found at the eleventh hour, it has often been at the expense of considerable "moral pressure," to say the least. On looking over the list of names, we notice that all, except perhaps one or two, will be qualified to compete for prizes; that is to say, they will not be qualified to practice their profession at the time when their papers are read. This is somewhat unusual, and will have the effect of making competition more keen, and the prizes, therefore, more valuable when obtained.

Some of the subjects are old and well worn, but the greater number are new and original, and many of them will, we have no doubt, provoke good discussions. We are glad to notice no less than four physiological subjects. These ought to induce men in their first and second years to take a part, for they cannot make the excuse we have so often heard from them, that they know nothing of the subjects, and cannot read them up without interfering with their regular work. It will be seen that the subject of the last paper is very nearly the same as that chosen for the prize essay, but as this paper must be delivered in the hands of the Presidents of the Society at least one week before the last meeting, and as the prize essays must also be delivered up by that time, the reading of the paper cannot interfere in any way with the preparations of the essays, but will only have the effect of creating additional interest in the subject.

Lectures on Midwifery.

—o—

By J. BRAXTON HICKS, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

LECTURE III.

After the head has escaped the vulva it makes a movement whereby the occiput is carried to the same aspect as that in which it presented at the commencement. For as the head is escaping, the shoulders enter the brim in the opposite diameter to that by which the head entered. But as the head had been made to assume the direction more or less towards the antero-posterior of the pelvis, the natural effect of the release of the head from the force would be to allow it to return to the original position, especially as the shoulders somewhat fix the long axis of the child steadily in the first direction. This movement has been called *Restitution*. Thus, it will be seen, that obliquity, rotation, and restitution are carried out by rotation on the vertical cranial axis; while flexion and extension occur by

rotation on the transverse axis. Now, the part of the head which "presents" in the first position is about the upper and posterior angle of the right parietal bone; as the head descends the "presenting part" is a little anterior to this. The shoulders engage the brim in the "left oblique," as it is called by some; the right shoulder to the left acetabulum. As descent advances, the right shoulder moves towards the symphisis pubis, as did the occiput; but the left or posterior shoulder inclining at the same time to the left side of the sacrum, sweeps over the inside of that bone, the coccyx, and the perinæum, escaping from the vulva; while, about the same time, the anterior or right shoulder passes beneath the pubic arch, and thus the shoulders are born. In some cases one arm is extruded at this time, but in others the fore-arms being extended, the arms are not delivered till the pelvis is about to escape. The pelvis of the child is, theoretically, supposed to occupy by its antero-posterior diameter the same pelvic diameter as the head did; but generally it passes through without any precise direction. The feet and legs generally remain in the vagina, at least, when the patient lies in a hollow in the bed, but if she be delivered on a harder bed than usual, the child gravitates sufficiently to draw them from the mother. Upon examining the head after delivery, very commonly, a swelling is detected on the scalp. This is called the caput succedaneum, or scalp tumour; it is produced before the full expansion of the os uteri, by the pressure of the os and lower part of uterus on the scalp, whereby the circulation is retarded and effusion occurs, generally the swelling is the result of serous effusion only; sometimes, however, blood is also mingled with it. Theoretically, it should be on the "presenting part," but as the os uteri is not always situated in the true axis, the swelling also is not so, as the head approaches and passes the vulva a certain addition is made to the swelling produced by the general pressure of the vagina and vulva. In the second position of the head, the movements are the same, substituting right for left, and left for right. But in the third and fourth positions the movements are not the same. Of course the same general principles obtain. But as the face is to the front, it is clear that extension cannot take place; on the contrary, increased flexion. And, necessarily, the occiput being driven against the sacrum follows its curve, and that of the coccyx and perinæum, till it emerges from the edge of the distended posterior fourchette. At the same time the face rotates towards the symphisis against the left descending ramus of the pubes, and descends proportionately as the occiput sweeps posteriorly, till the forehead emerges from beneath the pubic arch, and in succession escape the eyes, nose, mouth and chin. Then, if the occiput be not at that time external, it becomes so immediately, in consequence of the relief given by the escape of the chin. The face makes the "rotation" movement in these two positions, as did the occiput of nearly an eighth of a circle. In the third or "right occipito-posterior" position the left side is anterior, consequently the left parietal bone presents, and the "presenting part" is about the middle of its upper edge, shifting somewhat posterior towards the end of labour. In the fourth position the right is to be substituted for left and *vice versa*. Now, between the occipito-anterior and posterior positions there is much difference in the case of labour. The plane of the fœtal head, which engages the various planes of the pelvis is the sub-occipito-bregmatic, the smallest plane of all, and what is really of more importance the most compressible; while, with the occiput posterior the fœtal cranial plane engaged, is the frontal occipital nearly the longest; and nearly the most incompressible; and, still further, instead of circumstances improving as the head descends, it becomes worse in consequence of the straight and rigid face not adapting itself to the pubic bones. Thus, as the occiput descends on to the coccyx and perinæum, the only yielding is obtained from the soft parts, which, being put excessively on the stretch are very liable to be burst through when the pressure is exerted on the edge of the perinæum, and thus as a result we have "ruptured perinæum." Labour is, as might be expected, retarded, and this position is one of the causes of "tedious labour." But sometimes the face in the third position, instead of rotating forwards, moves backwards towards the sacro-iliac synchondrosis, and reduces the position to that of the second, or right occipito-anterior, in which case labour is carried out according to the plan already described. It will be perceived, upon due consideration of the above points, that the amount of divergence of the sides of the pubic arch has much influence upon the facility with which the head passes through the bony outlet. Should the angle be too acute, the head is pressed backward more or less forcibly, and this is a very common cause of "ruptured perinæum." But the fœtal head is capable of being moulded considerably, so as to enable it to pass through a pelvis otherwise too small. For the sutures of the vault are loose, and the bones can thus overlap each other to a slight degree: this movement is sometimes more extensive than the dura mater can withstand, and the serrations may penetrate the longitudinal sinus, death resulting by effusion of blood. The amount of diminution of the bi-parietal diameter is seldom more than half an inch, but the laxation of the sutures permits a general inclination of the head over the occiput, or, in other words, the bregma, or top of the head is thrown backwards. This causes a lessening of the vertical diameter, and thus in two directions the sub-occipito-bregmatic plane of the fœtal head is diminished. The compression, however, is not without damage to the child's brain, or danger to its life. No doubt the compression necessarily resulting from the movements above, more or less injures the brain. Hence, in a difficult labour, an easily moulded head permits possible damage to the fœtal brain, whilst the hard head prevents injury to to the child, but may cause injury to the mother.

Clinical Lecture.

By J. Cooper Forster, M.B., F.R.C.S.

Surgeon to, and Lecturer on Surgery at, the Hospital.

EPITHELIOMA.

The subject of the lecture was an old woman, aged 68. She was admitted into the hospital with a large swelling on her forehead, and the history was very characteristic of the disease, which was as follows:—

Some months ago she noticed a small pimple on her forehead, about the middle; she rubbed this off as often as it came, but as it persisted and increased in bulk, she went to a doctor, who sent her here. On admission, the patient stated that her health was quite good, but that she wished to get rid of the tumour. A round lump is to be seen occupying the median line of the forehead; it is moveable

over the frontal bone, and from various parts of it a little pus exudes; it feels soft, and the surrounding tissues look a little red, there is no enlargement of the cervical glands. The surface of the growth is rough and nodulated; it is ulcerated also, and when the scab covering it is removed, the tumour is seen to consist of distinct lobules, separated by sulci, which give it an irregular appearance.

What, then, with such a history, and the patient before you, can the nature of the growth be?

It might be one of two things, viz., an inflamed sebaceous follicle, or an epithelial growth; how are we to diagnose between them? It cannot be a sebaceous follicle, because such growths are smooth and regular on the surface, and it is most probably *an epithelioma*, because it has all the characteristics of such growths, viz., a rough nodulated outline with distinct sulci, and an ulcerating surface. It is in an unusual place for epithelioma to appear, the usual site being the junction of mucous membrane with skin, *e.g.* the lips. The scrotum and the angle of the eye are also common places for these tumours to appear. When the lips are involved the cervical glands generally become enlarged. Epithelial growths are more common in males than in females. This growth may not recur; if it does it will probably be after many years in the cervical glands. These growths consist of masses of epithelial cells. Round about the tumour are little nests of these cells, and therefore the incision for removal must be made wide of the growth, or else the epithelioma will probably re-appear, or at all events there will be a greater prospect of its doing so.

The dresser then proceeded to remove the tumour by making an elliptical incision through the surrounding skin (taking care not to keep too close to the growth) from below upwards, so as not to divide the fibres of the occipito-frontalis transversly.

Mr. Forster remarked that it was difficult to arrest hæmorrhage in wounds of the scalp, *by torsion*, but pressure would immediately stop the bleeding. With respect to sutures, in Mr. Forster's own recollection, no less than five different sorts have been in fashion, each one being vaunted as superior to the one which went before, viz.: silk, platinum wire, iron wire, gilded wire, and now carbolized cat-gut. This last has the advantage of being absorbed in the wound. In this operation it is a matter of perfect indifference which kind is used, but in wounds about the vagina Mr. Forster always uses wire, which wire does not signify.

MALIGNANT DISEASE OF BONE.

This was the case of the patient who was operated on, on the 20th ult.

A girl, æt. 20, from the country, was admitted into the hospital with a large swelling over the lower end of the tibia and fibula. Her history was that previous to her present ailment she had always enjoyed good health. Six months ago she noticed a large swelling outside her ankle, this almost disappeared with rest and poultices, but in spite of it the growth increased in size.

Probably six months ago there was inflammation and thickening about the ankle, which rest and suitable application *almost* dispersed, but the swelling which remained acted as a foreign body, setting up inflammation and re-producing the old trouble.

A large oval tumour extended from the tip of the external malleolus half way up the leg. The tumour was pulsatile.

What could be the nature of the swelling? Fluid? If so, what kind? Supposing it to be fluid, what would probably be the diagnosis? A chronic abscess? Strumous disease of ankle joint? This it could not be, because the ankle joint was not involved but quite free. Was it a blood tumour? No, because there was no history of a blow. Was it a bursa? It might just possibly be, but the site was most unusual for such a complication. Surrounded by such difficulties, what was the proper way to proceed in making a diagnosis? What any one would be justified in doing, viz., introducing a grooved needle, in order to draw off some of the fluid for examination. This was done, and nothing but blood came out, but as there was no history of of a blow, it was hardly likely to be a blood tumour. The pulsation, upon careful examination, was found to be more an upheaval than ordinary pulsation, which would lead to the supposition that it was a cirsoid aneurism (aneurism of artery and vein.)

Mr. Cock and Mr. Birkett saw the case. Subsequently it was again tapped, and again blood came out, this time in jets as if an aneurism had been punctured. What growth could this be, having all the foregoing facts before us? It could be but one, viz., a pulsating tumour of bone (a form of disease very rarely met with) called an osteo-aneurism.

Having arrived at the conclusion that the growth was not an aneurism, Mr. Forster made an incision through the skin into the tumour (the patient being under chloroform, and an Esmarch's bandage having been applied) which proved the diagnosis of circoid aneurism to have been wrong, although the treatment was quite right. The growth was malignant, and such being the case, Mr. Forster amputated the leg. He regrets somewhat that he did not perform the operation through the thigh or at the knee joint, as the growth would have been less likely to recur at the end of the stump, which it may do now, or else in the inguinal glands, some of which are enlarged, still there were other reasons why it could not be done at either of those places, one of which was that the consent of the girl had hardly been obtained even for amputation at all, but for exploration. These pulsating tumours of bone occur most frequently in the iliac region. In all probability this bone would have shortly broken spontaneously; this is characteristic of osteo-cancer. Osteo-aneurism is another name for these beating tumours.

Physical Society.

The third meeting of the present session was held last Saturday, the Treasurer of the hospital being present. Mr. H. Clarke was in the chair, and a paper was read by Mr. Jumeaux on "Talipes."

Mr. JUMEAUX described the causes and treatment of Talipes. He said that the main object of his paper was to introduce to the notice of the society an instrument which he had invented for the cure of this deformity. He briefly sketched the history of Talipes; then passed on to notice the various forms of Talipes—equinus, varus, valgus, and calcaneus, and the more complex ones—formed of combinations of the above—equino-varus and valgus—and calcaneo—varus and valgus. He analysed their causes, enumerated the abnormal changes resulting, and then proceeded to speak of the treatment to be adopted in each case—though in all it would be found to be very similar; remarking that what the surgeon had to do was to overcome the shortening of the muscles, ligaments, fascia, and integuments on the contracted side of the foot; to direct the bones into their proper positions, to educate the patient's voluntary use of the part; to give strength to the muscles on the elongated side of the foot, and to resist any tendency to relapse. He recommended in the first place using splints, bandages, &c., but

if this did not succeed tenotomy must be resorted to; once having established the necessity of this operation, the earlier it is done the better. He then proceeded to demonstrate the application of his instrument. The contrivance appeared to be very ingenious, and in its greater range of applicability to be superior to Scarpa's or any other apparatus for the cure of this deformity. It is applicable to either foot, and, by means of a cog-wheel, with a catching-spring to fix it, it can be adapted to any of the varities. By means of a side-spring, so as to fit either side of either foot, inversion or eversion is overcome. John Millikin, of St. Thomas's Street, is the maker. It is applied to the foot by means of straps.

Mr. Richards opened the debate, apologizing for the absence of Mr. Vinter, who read the last paper.

Mr. Coley thought there were two causes of talipes, spastic contraction, and paralysis; in the latter electricity was more useful than the knife. He had found strapping better than bandaging in cases of congenital talipes.

Mr. Fry said Mr. Jumeaux had not stated what cases he would apply his instrument in, he thought it too large for congenital cases. Would he advise a boot to be worn under? He had seen a very useful wooden splint applied in a case of talipes equino-varus in Dorcas Ward.

Mr. Dring thought Mr. Jumeaux's instrument very useful, but doubted if it could be used for all forms of talipes He would like to know the best treatment to adopt in accidental division of the posterior tibial artery.

Mr. Green wished Mr. Jumeaux had brought forward some cases to illustrate the use of his instrument. He thought that operators often failed to divide the tendons when they thought they had succeeded.

Mr. Lancaster said the treatment by elastic bands had not been mentioned. He had seen a case successfully treated by that means.

Mr. Brett mentioned chloroform as being sometimes useful. He had seen an instrument made with a door-spring for talipes equinus.

Mr. Hetley thought the objections which had been made to Mr. Jumeaux's paper unfounded, he probably had no opportunity of getting cases. The size of the instrument might be varied. He had often found the present treatment of talipes unsatisfactory, especially that by elastic bands. In a case of wounded posterior tibial artery he would simply apply a pad.

Mr. Shadwell mentioned worms, teething, &c., as frequent causes of talipes. He liked Mr. Jumeaux's splint, especially its adaptability to either foot. If the posterior tibial artery were punctured in tenotomy, he would completely divide it.

Mr. Morgan did not think it was always bad surgery to divide the arteries, and mentioned a case where both had been divided.

Mr. Symonds thought Mr. Jumeaux's splint very ingenious, and said that the other treatments which had been mentioned did not affect its usefulness. It was especially applicable after tenotomy.

Mr. Larkin thought the position of the child's foot in utero might account for some cases of congenital talipes varus. He had carefully examined Mr. Jumeaux's splint, and thought it very ingenious.

Mr. Pedley said that all the movements in Mr. Jumeaux's splint obtained by several joints might have been obtained by as ingle ball-and-socket joint.

Mr. E. Duke thought much depended on the strength of the elastic bands used in talipes, and mentioned a case where they had been used. He thought the lightness of Mr. Jumeaux's splint a great recommendation.

Mr. McCarthy wished a little more comparison had been made between Mr. Jumeaux's instrument and some others. He would like to know what advantage it possessed over Stromeyer's.

Mr. Symonds said that a ball and socket joint would be more expensive, and no better than the cog-wheels.

Mr. Jumeaux having replied,

Mr. Hetley moved, and Mr. Tyson seconded, a vote of thanks to the reader of the paper.

The Chairman announced that the next paper would be read by Mr. Coley on "Gastric Ulcer."

The meeting then adjourned.

The following list of papers to be read before the Physical Society during the present session has been issued by the Presidents:—

1874.

Saturday, Oct. 10th, Mr. H. F. Lancaster, "The operation of Turning as a means of Delivery."

Saturday, Oct. 24th, Mr. J. H. Vinter, "Chloral Hydrate."

Saturday, Nov. 7th, Mr. Jumeaux, "Talipes or Club-foot."

Saturday, Nov. 21st, Mr. F. C. Coley, "Gastric Ulcer."

Saturday, Dec. 5th, Mr. J. M'Carthy, "The physiological effects of Chloroform."

Saturday, Dec. 19th, Mr. J. H. Poland, "Alterations of Temperature after Ingestion of Food."

1875.

Saturday, Jan. 9, Mr. J. M. Hobson, "The Morbid Sounds of the Heart."

Saturday, Jan. 23rd, Mr. E. Amphlett,

Saturday, Feb. 6th, Mr. St. C. B. Shadwell, "The Treatment of Rheumatic Fever."

Saturday, Feb. 20th, Mr. C. J. Symonds, "On the Influence of the Relation between Blood and Tissues on Circulation."

Saturday, March 6th, Mr. W. A. Kidd, "Purgatives."

Saturday, March 20th, Mr. R. E. Carrington, "The Physiological Action of Alcohol."

Operations.

Friday, Nov. 6th.

Mr. Davies-Colley removed a lipoma from the antero-superior aspect of the right shoulder. It was easily turned out through a horizontal incision. No sutures were applied; antiseptic treatment throughout.

Mr. Durham removed a carcinomatous mass from the upper and outer portion of the left breast of a married woman, aged 44. It had been growing four months, more rapidly during the last month. Skin adherent to nipple, but slightly contracted. A section showed it to be almost typical of an infiltrating scirrhus.

Mr. Davies-Colley removed several polypi from the nostrils of a young woman, which had resisted all previous attempts made without chloroform.

Mr. Howse removed a nævus, in the electrifying-room, by means of the galvanic cautery.

Tuesday, Nov. 10th.

Mr. Birkett amputated through the leg at the junction of the upper and middle thirds, by lateral skin flaps, the muscles being cut through by a circular sweep of the knife.

This was a case of old compound fracture, involving the ankle joint, in a man aged 30, showing no intention of healling.

Mr. Bryant amputated through the middle third of the leg, making a long anterior oval skin flap and a short posterior one. Skin flaps dissected up, and muscles divided circularly. Torsion and sutures. This was a case of elephantiasis involving the whole of the structures of the foot and lower portion of the leg. Quite soft, the knife cutting through without resistance. Section showed a very thick layer of white œdematous fat beneath the skin. Muscles fatty and wasted, but swollen. Posterior tibial nerve enlarged spirally. All the bones full of fat. Cancellous tissue entirely gone, and only a shell of bone remaining outside.

Mr. Davies-Colley removed the nasal bones and a growth involving them, from a woman aged 74. This was a case of Mr. Bryant's, who, a week or two since, removed a carcinomatous mass from the same situation. Since then the growth was found to have implicated the nasal bones, which, with the septum, were partially destroyed. The skin only surrounding the anterior nares was left, and the surface cauterized.

The Surgery.

—o—

Dislocation of the Shoulder.—This occurred in a woman, 74 years of age, and was sub-glenoid in character. The usual signs were present, such as fixity of the arm, the arm abducted from patient's side, great flattening of the shoulder, and the head of the bone plainly felt in the axilla. The woman was very thin, so that all the "points" about the shoulder could be well made out. Chloroform was administered, and the dresser quickly reduced the bone, employing the common method of heel in axilla, and applying extension. The great age of the woman, and the character of the dislocation, are worth noting

There have been two other dislocations of the shoulder, occurring in men, and of the usual kind, sub-coracoid. One was reduced quickly without chloroform, the other with some difficulty. The bone in the latter case had been out of place for 24 hours, chloroform had been given, and the usual mode of reduction had been tried some few hours previous to attendance here; when he was first seen the shoulder was swollen, and the head could only just be felt under the coracoid process; powerful extension failed at first, but after some manipulation, extension again being tried, the head of the bone slipped back into its socket.

Dislocation of Radius and Ulna.—The patient was a middle-aged man, Upon examining his elbow-joint there was a depression quite at the lower part of the posterior surface of the humerus; the head of the radius and the ulna were thrown forwards, and there was also a depression in front of the elbow-joint. Crepitus was detected on moving the two condyles. The dislocation was reduced by forcibly flexing the joint, afterwards an inside angular splint was applied.

Foreign Body in Left Nasal Cavity of a boy aged three and a-half years. Towards the end of last May, the boy was playing with the amber mouth-piece of a pipe, and accidentally got it fixed in his nose. There it had remained until he was brought to the hospital. On passing a probe the amber could be detected; it was loosened by this method, and finally extracted by dressing forceps. The bleeding that followed soon ceased.

The following Guy's men passed the recent second M.B. Examination at the University of London:—First Division—Messrs. H. S. Branfoot, T. Eastes, J. A. Rigby. Second Division—Messrs. H. Ashby, T. S. Morley, G. H. Percival.

The following gentlemen, students of this Hospital, satisfied the Examiners at the Primary Examination held last week at the Royal College of Surgeons:—Messrs. H. W. Ewen, E. F. Ingram, W. Tarrant, O. T. Slatter.

At the recent examination for prizes in Materia Medica and Pharmaceutical Chemistry at the Apothecaries' Hall, a silver medal and a book were awarded to Mr. John Davies, of Carmarthen, student of this Hospital, for his proficiency in those subjects. We understand that the gold medal was not awarded.

The Annual General Court of the Governors of the Hospital was held on Wednesday last. Owing to illness the President was not able to be present. After the transaction of business, the Treasurer, accompanied by several of the Governors, visited the wards as usual. The Annual General Court Dinner will be held on Wednesday, the 25th inst.

As will be seen in another column, there have been a large number of accidents admitted during the past week, chiefly of the lower extremity. There have been two primary amputations of the thigh, and two operations for the relief of strangulated hernia—one femoral, the other inguinal; both are doing well.

Spontaneous Combustion.—The vexed question of the possibility of spontaneous combustion has again lately been discussed before the Paris Société Chirurgie, in a paper by M. Chassagniol of Brest. The author stated that spontaneous combustion was first mentioned in 1692, since which time it had found a certain number of partizans in France. The Germans, however, with M. Casper at their head, entirely deny its possibility. M. de Chassagniol has endeavoured to sift the truth from the conflicting accounts on record, and has, for this purpose, tried to find some authentic facts. He has not, however, been able to do so in any scientific records; no medical man, no person of authority has ever been present at a case of spontaneous combustion of the human body. Many authors have affirmed that the human body burned on these occasions with a blue flame, and diffused an empyreumatic smell, but these characteristics are met with in many kinds of combustion. Instances have been sought for in alcohol-drinkers, especially amongst women, but hitherto without success. It is really a question whether the possibility of spontaneous combustion of the human body can be theoretically demonstrated. The original idea was that the alcohol in drinkers took fire. Dead bodies, or portions of dead bodies, however, burn but very slowly, even after being steeped in alcohol for some days. After having injected alcohol into the veins of dogs, it was found impossible to obtain combustion of these animals; electric combustion was then tried, and finally, the presence in the human body of a gas which would either light up spontaneously, or on a light being brought near to it, was sought for. Numerous analyses have not been able to show the presence of sulphuretted hydrogen in the different parts of the human body. In later times it has been a question if a resemblance could not be found between the spontaneous combustion of stacks of hay and straw, and that of the human body, but there is really no analogy between them. M. Chassagniol is, therefore, necessarily brought to the conclusion that the fact of spontaneous combustion is not made out; and M. Horteloup, who read his paper for him before the Société de Chirurgie, strongly doubts if any case of spontaneous combustion in the human subject worthy of serious attention has ever been brought under notice.—*Medical Record.*

Obstetrics.

A. H., æt. 34, was admitted on Oct. 6th, with uterine disturbance. On taking her history, she gave symptoms of vesical calculus. She stated that two years ago she felt severe pain in the left loin, for about a week, and soon after micturition became frequent and painful; the urine often stopping short whilst being voided. Sharp and forcing pains were felt at the meatus. These symptoms have become more severe for the last three months. She has frequently passed blood with her urine. The urine was high-coloured, sp. gr. 1020,—contains lithates, mucus, and a slight trace of albumen. The sound was passed, and a stone readily detected. On Nov. 6th patient was placed under chloroform. The three-bladed female urethral dilator was then introduced about an inch, and in a few minutes sufficient dilatation effected to allow the index finger to be passed into the bladder, and a fair sized stone to be felt. Along the finger the forceps were passed, and the stone easily removed. It proved to be a lithatic calculus, coated with phosphates. For a few hours after the operation the urine dribbled away, but the same evening she was able to hold it an hour; it was voided with much pain, and at first contained a little blood. She is now regaining power over the bladder gradually.

E. A., æt. 25, married. Has had three children, and one miscarriage, which took place in May last. In July last she again became pregnant, and went on quite naturally until Nov. 2nd, when she found that she was unable to pass any water. On Nov. 5th she came to Dr. Galabin as an out-patient. On examination it was found that the uterus was retroflexed; the bladder was distended, forming a soft, fluctuating tumour, reaching to the umbilicus. A catheter was passed, and three half-pints of urine drawn off. She was admitted on Nov. 6th. A catheter was again passed and the water drawn off; after this a full injection was thrown into the rectum, and the fluid pressure thus applied was sufficient to reduce the displacement of the uterus. Patient has quite lost her trouble, and is now perfectly well.

A. H., æt. 33. Married six years. Has never had any children, nor any miscarriage. Three years ago she began to suffer with menorrhagia, leucorrhœal discharge in the interval between the periods, and pain in the pelvis and back. These symptoms continued until November, 1873, when she lost the pain, and the hæmorrhage became almost continuous, the quantity being a good deal increased at each period. On admission, patient is very anæmic, though not much wasted. On examination per vaginum, a large fleshy mass is felt, filling the whole vagina, running up into the cervix, where it is attached by a broad pedicle. The growth, consisting of a large polypus, was removed with the wire écraseur, and the patient is now going on fairly. There has been scarcely any hæmorrhage since the operation.

The Dissecting-room.

The supply of subjects to the dissecting-room this session has been curiously irregular. Last week we remarked upon the sudden and unusual increase in the number of bodies sent to us, and this week we have to record that no subject has been received since our last report.

The primary examination at the Royal College of Surgeons being over, demonstrations for second year's men will commence next week. Mr. Lucas will give the first on Monday, at twelve o'clock, on "The Triangles of the Neck." Four gentlemen presented themselves for the "First College" last week. All passed.

Sports.

FOOTBALL.

Last Saturday the Guy's first fifteen went down to Battersea Park to play against St. George's, and we regret to record that they sustained a defeat. It is only right to mention, however, that Guy's played without several of their best men, notably Gray and Pearson, and throughout the greater part of the game they played one man short, owing to one of the forwards being hurt at the commencement.

The St. George's forwards played up very fast and well, going into the scrimmages with a run, and nearly always pushing our men over. Behind the scrimmages Collins, who, it will be recollected, played for England last year, was in very fine form, and made some excellent runs and drop kicks. McKay also played well for St. George's. For Guy's, Mutch and Wallis, amongst the forwards, played very well, both being frequently conspicuous. Finch also did good service. Breach, as back, was very safe as usual, and several times prevented a run in. The ground being small, was eminently favourable for kicking, and, unfortunately, Guy's were deprived of their best drop-kicks, while Collins, for St. George's, dropped beautifully. The result of the match was that St. George's scored a goal (dropped by Collins with his left foot), a try, a touch in goal, and several touch-downs to nothing. Forwards.—Pinching (captain), Gilbert, Wallis, Welchman, Wells, Keer, Mutch, Collins, Hetley, and Boughton. Half-backs.—Finch and Maclean. Three-quarter-back.—Roper. Backs.—Robson and Breach.

Guy's (II) v. Beckenham F.C.

This match was played on our ground at Blackheath on Saturday last, and, after a very good game, ended in a victory for the visitors by a goal (dropped by Stoneham) and a try to nothing. Had our men played as well before as they did after half-time, the result would have been very different. As back, Bain played well, whilst among the forwards Roberts was especially noticeable.

The following team represented Guy's:—Messrs. Brown (captain and three-quarter-back), Reader and Jumeaux (half-backs), Bain and J. H. Poland (backs), A. Carey, T. Duke, D. D. Roberts, Mansell, Maltby, Peskett, Mainwaring, A. Poland, F. J. Wilkinson, and Chapman (forwards).

We understand that a match is arranged between the United Hospitals' Football Club and the Civil Service Club to be played at Lillie Bridge, on Wednesday, Nov. 18th, at three o'clock. The following will compose the medical team:—

Full-backs.—Messrs. Prowse (London) and Pearson (Guy's).

Three-quarter-back.—Mr. Alford (University).

Half-backs.—Messrs. Collins (St. George's) *Captain*, and Gray (Guy's).

Forwards.— Messrs. Pinching (Guy's), Manders (St. Mary's), Sherwood (St. George's) Turner (St. George's) Gilbert (Guy's), Jefferson (King's), Chapells (Middlesex) Keetly (Bart's), Biggs (University), and Pinnell (University).

ROYAL COLLEGE OF SURGEONS.

The following paper was set last week at the primary examination for the diploma of member, Nov. 7, 1874:—

1. Describe the course and distribution of the branches of the ophthalmic division of the fifth nerve.

2. What are the anatomical peculiarities by which the fœtal circulation is distinguished? and what purposes do they respectively serve?

3. Describe the ischium; name the muscles attached to it, or in relation with it; and state what are their respective uses.

4. Describe the minute structure of the female breast. State what is the microscopic appearance, and what are the chemical constituents of human milk; and why is it regarded as a typical food.

5. Give the dissection necessary for the display of the internal mammary artery; name its branches, and point out the chief anastomoses which they form.

6. State what is usually understood by reflex nervous action; and give some simple examples of it.

APOTHECARIES' HALL.

The following were the questions at the Hall, on Wednesday, October the 21st:—

Medicine.

1. Contrast the fatal terminations of typhus, with those of typhoid.

2. Explain the following words:—sibilus, phonchus, fine crepitation, large crepitation, gurgling; state under what circumstances these sounds are usually produced.

3. Mention the principal entozoa and the organs they severally inhabit. How would you treat tapeworm?

4. What are the chief causes of deafness? What is the treatment of those varieties which come under the physician's care?

Pathology.

Describe the changes the brain undergoes during and after apoplexy and abscess.

Therapeutics.

What are the general therapeutical agents employed in valvular disease?

Midwifery.

1. Distinguish between the early indications of head, face, and breech presentations. How do you manage a face case?

2. Give the usual causes and the treatment of hæmorrhage after the expulsion of the placenta.

3. Explain the morning nausea and sickness of pregnancy, and give the best known methods for its relief.

Forensic Medicine.

1. What is the earliest period at which a viable child may be born? Describe such a child.

2. In a case of chronic arsenic poisoning, what are the symptoms and treatment?

3. After a fatal epidemic disease in a house or public institution, what precautions should be taken for further prevention?

4. What are the tests for corrosive sublimate, copper, zinc?

Clinical Case.

Mitral disease and Bronchitis.

The Wards.

MEDICAL.

The following Cases were admitted between Oct. 28 and Nov. 11:—

ADDISON.—2—Mitral regurgitation and albuminuria. 9—Climacteric. 23—Albuminuria. 29—Erysipelas (facial). 31—Quinsy. 32—Rheumatic fever. 42—Chronic Bright's disease.

BRIGHT.—10—Bright's disease. 12—Chorea. 14—Abdominal pulsation.

PHILIP.—5—Alcoholism. 11—Rheumatism and aortic regurgitation, 24—Tumour in left hypochondrium—malignant (?)—spleen (?) 27—Phthisis. 37—Phthisis. 39—Phthisis.

STEPHEN.—3—Chronic rheumatism—Morbus cordis. 4—Diabetes 6—Acute rheumatism. 7—Chronic rheumatism. 8—Enteric fever. 13—Diabetes. 19—Phthisis. 20—Sub-acute rheumatism. 22—Chronic Bright's disease. 24—Chronic Bright's dsease. 25—Enteric fever. 26—Acute tubular nephritis, 30—Morbus cordis—sciatica. 35—Bronchitis. 36—Chorea. 37—Acute tubular nephritis. 38—Acute rheumatism. 40—Phthisis. 45—Jaundice. 46—Acute rheumatism. 47—Acute tubular nephritis. 49—Hœmoptysis.

MARY.—4—Gastric ulcer. 5—Chlorosis. 6—Acute rheumatism. 8—Hydatid (?) of kidney. 10—Hemiplegia (puerperal). 13—Enteric fever, 14—Epilepsy. 16.—Cephalalgia. 21—Bronchitis and emphysema. 23—Acute rheumatism. 30—Polypus. 31—Retroflexed pregnant uterus. 34—Polypus. 41—Ovarian tumour—polypus. 42—Parametritis. 43 Extra-uterine fœtation (?) 45—Hypertrophy of mucous membrane of cervix.

SURGICAL.

The following cases were admitted between Nov. 4 and Nov. 11:—

CORNELIUS.—1—Fractured fibula. 2—Fractured neck of femur 5—Fractured spine—compound fracture of femur—death. 11—Fractured fibula. 12—Wound of anterior tibial artery. 13—Compound comminuted fracture of leg—amputation. 14—Fractured tibia. 16—Fractured tibia and fibula. 17—Compound fracture of left femur—amputation.—Dislocation of right femur—reduction—death. 17—Fractured patella (transverse). 20—Fractured tibia and fibula.

LUKE.—3—Calculus in urethra. 4—Fractured tibia and fibula. 5—Compound fracture of humerus. 6—Hernia—operation. 11—Fractured ribs and patella (transverse and comminuted). 12—Fractured tibia and fibula. 26—Pyæmia.

CHARITY.—7—Scald—tracheotomy. 7—Lipoma—excision. 11—Burn. 11—Epistaxis. 13—Fractured tibia and fibula—tenotomy. 15—Herniotomy. 24—Fractured tibia and fibula.

ACCIDENT.—No admissions.

LYDIA.—1—Hernial protrusion after ovariotomy. 2—Disease of wrist. 9—Elephantiasis Arabum. 20—Bursitis patellæ.

DORCAS.—18—Carcinoma mammæ. 20—Eczema.

JOB.—4—Stricture. 5—Ulcer of leg. 7—Disease of knee. 10—Disease of tarsus. 17—Calculus vesicæ. 21—Carcinoma testis.

NAAMAN.—5—Sloughing wound of thigh. 15—Double curvature of spine.

MARTHA.—6—Hysteria (?) 9—Ulcers of leg. 11—Abscess on thigh. 13—Rheumatic arthritis. 15—Disease of hip.

LAZARUS.—8—Absorbent inflammation. 10—Cystitis.

The Editors acknowledge, with thanks, the following honorary subscriptions:—Mr. Henry Moon, £1 1s.; Dr. Galabin, £1 1s.; Mr. Durham £1 1s.; Mr. Davies-Colley, £1 1s.; Mr. Laidlaw Purves, £1 1s..

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Guy's

Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 8. SATURDAY, NOVEMBER 21, 1874. TWOPENCE

A FEW weeks ago, whilst advocating the desirability of the establishment of a new special department for the study of cases of temporary insanity, in connection with this Hospital, we remarked on the excellence and completeness of the special departments as a characteristic feature of the Guy's Clinical School. We are sorry to have to come to the conclusion that students are often either careless as to the value of these, or ignorant of the importance of diligently attending them. We feel sure it is necessary for them to do so in order that they may practice their profession successfully and creditably to themselves, and also that they may possess sufficient practical knowledge of the subjects to enable them to consult with any specialist whom they may have occasion to call in. If we visit the wards, we find no lack of students regularly accompanying the different Physicians and Surgeons on their rounds; but if we extend our visits to the out-patients' rooms, we find the number of students attending these to be always very considerably less, and in the special departments to be still fewer. We refer more particularly to the Ophthalmic, Aural, Obstetric and Cutaneous departments. The Dental, perhaps, is hardly so important, since duly qualified dental surgeons are now so numerous, as to almost entirely relieve the general practitioner of that class of cases. Now, we wish to urge the injustice men do themselves, by constant attendance in the wards—however praiseworthy that may be—at the expense and neglect of the special and general out-patients' departments. The out-patient cases, be it remembered, are the very class of cases that a general practitioner sees, and is called upon to treat, every day of his life; and among the specialities, in particular, are found the very cases, where unskilful treatment will produce the most disastrous results to the patient, and reflect the utmost discredit on the surgeon. We never yet met with a practitioner who regretted the time he spent in the special departments; but we have known several, who have had good reason to deplore their almost entire neglect of them. The cases that present themselves are those that no amount of mere book-knowledge will enable a man to diagnose or treat successfully. For instance, we should like to know, who could without practice pass a probe into the Eustachian tube, make use of the ophthalmoscope, or diagnose the many varieties of cutaneous affections, requiring, each, a different mode of treatment?

We imagine that men, feeling the amount of work before them, put off their attendance on these departments until they have got through their examinations, thinking then to have plenty of time on their hands. In nine cases out of ten this period of ease and plenty of time never comes; for as soon as a student is qualified, there arises the desire to make use of the qualification, and he leaves the Hospital with the promised attention to specialities totally forgotten, or remembered only too late, when time and bitter experience cause him to find out the extent of his irremediable mistake.

It is superfluous, we are sure, to dilate upon the variety and number of diseases that present themselves, and the sound practical teaching that the various cases elicit from the respective Physicians and Surgeons. We would urge our fellow-students to spend an hour or two every week in

some special department. It will be found to be a pleasant relief from the routine of ward work, and will amply repay them in the amount of fresh and interesting information thereby secured—information which will make the usually dry and irksome reading of the subjects in text-books, easy both to acquire and retain.

Lectures on Midwifery.

By J. Braxton Hicks, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

Lecture IV.

The reason why at the eleventh monthly epoch labour should begin, has been a source of much discussion. Some have likened the ovum to ripe fruit or leaf; but this gives no explanation. Some have explained it partially by pointing out that at each month the uterus is more irritated; and that congestion occurs then more than during the intervals. Some have also partially explained that the placenta is beginning to undergo changes towards the end of pregnancy, which, if extended, would render it unfit for its function. Doubtless these are facts; but probably there is a combination of these and other circumstances which, coinciding, culminate in the expulsion of the ovum, and they are these: The uterus throughout the whole of pregnancy is frequently contracting—unfelt in general, but sometimes perceptible—at each month it is more sensitive to reflex irritation. Towards the end of pregnancy the uterus becomes so distended as to occupy the whole of the abdomen, pressing against the ribs, &c. When it can no further ascend, the pressure of the ovum against the lower part of uterus and its mouth is increased; the reflex irritation ensues, which causes, by the contraction of the fundus, a further pressure on the inside of the os, and a further reflex irritation; and thus a gradually increasing force is generated. The uterine contractions being always in action it requires only a slight increase of them to bring on labour, and this we can do at any time during pregnancy.

Different Stages of Labour.—The division of the different stages of labour are somewhat artificial, but nevertheless they enable one to understand the whole process of labour with greater facility. Perhaps the best classification is the following:—

Preparatory
Dilatation } Labour proper
Expulsion }
Supplementary

The Preparatory Stage would extend to the commencement of labour pains: the Dilatation Stage to the full dilatation of the os uteri, and possibly to the rupture of the membranes: the Expulsive up to the expulsion of the fœtus: and the Supplementary to the expulsion of the placenta.

Preparatory Stage.—About a week or two before labour commences the size of the abdomen seems to be slightly diminished. It may possibly be owing to the absorption of the liquor amnii. The patient is thus more comfortable, there is less pressure, and the child is lower down in the pelvis.

A few pains may occur, but they do not appear regularly; the pains are simply due to the natural peristaltic movement of the uterus, which, becoming more vigorous, the parturient woman is conscious of their existence. The reflex excitement is carried to the bladder and rectum, which become somewhat more irritable; there is often diarrhœa for two or three days before labour, emptying the rectum, so that the fæces should become no impediment to the passage of the child. Frequent micturition often occurs. The appetite is much increased, and the patient eats more hastily the last two or three days than during the whole previous time of pregnancy, often setting about their house-work apparently free from any discomfort. There is an increased secretion from the vagina; this is well-marked often, and may occur three or four days before labour begins.

Dilatation Stage.—It is said to commence when pains have begun to be more or less regular, with incipient dilatation of the os uteri. But sometimes it is very difficult to judge by the pains alone when labour has actually commenced, for it not infrequently happens for days before labour can be said to have begun that pains sometimes occur for many hours or even days without the initiation of labour.

Again, on the contrary, the full dilatation stage may be completed without any consciousness on the part of the woman; and this is doubtless the explanation of those cases of precipitate labour occasionally met with.

The pains gradually become more and more frequent: their duration longer. The patient complains, not of her back, but of the abdomen, in fact of the uterus itself, and she will often mistake it for stomach-ache.

It is said that you can tell the stage of labour by the character of the cry; at first she does not exclaim, but as she is talking she will for a short time stop, and as soon as the pain is over will proceed. After a time she will begin audibly to express herself at first in a sharp peevish cry; later this is more suppressed, with holding of the breath. The temperament becomes irritable with fear and tremblings. The stomach very often symathises and vomiting is produced. It is a common saying that "a sick labour is a safe one," and you must not suppose that because the patient vomits freely there is necessarily any danger connected with it. Rigors may come on towards the end of the dilatation stage; sometimes there may be only a little shuddering, but at other times almost a convulsion. About the end of this stage there is what is commonly called the "show." The "show" means a small show of blood; it never ought to cause any anxiety, sometimes being just sufficient to tint the mucus that passes away; it is a sign that the os uteri is becoming fully dilated. It is caused by the rupture of the few vessels which remain between decidua uterina and the uterus. The os uteri is rather backwards and high up at first, but after a little while it gets more forwards and settles down upon the brim. Just before each pain commences the membranes on the presenting part, if they are ruptured, slightly recedes, and the os uteri is tightened; then, as the wave of contraction passes up higher and towards the fundus, the lower portion of the uterus relaxes, and the presenting part ascends more or less. Before the pain begins, if the membranes have not ruptured, one can feel the presenting part through the membranes; but when the membranes become tense, nothing but the tight bag of membrane is to be felt. To preserve the membranes intact, which is the rule as long as possible, a too vigorous examination must

not be made; the examining finger should be kept close to the vaginal wall; after these pains have continued in rapidity and duration till the os uteri is fully dilated—first, by the mechanical distension by the bag of membranes, then the mechanical dilatation by the contraction of the longitudinal fibres, and thirdly by physiological reaction; and thus the os is opened sufficiently for the child to pass through. Generally speaking at this time the membranes rupture on the liquor amnii escapes, and the dilatation stage is over; and now the expulsive stage commences or rather continues the process. For, the lower the head descends the larger is the area of surface under irritation, and the lower the head is situated in the vagina, the more spinal nerves are to be found.

Expulsive Stage.—Up to this time there has been little assistance from the auxiliary force, but now as the head passes down, especially through the os uteri, increased reflex irritation is set up, and the lower the head descends, the more increasingly do the auxiliary forces exert their power up to the time; at last the head escapes from the vulva.

The pains occur at first at intervals of an hour to half an hour, which gradually decrease in duration until at last they may be of only three minutes interval. Each pain increases in length as the interval diminishes, so that at last the intervals are almost imperceptible between the pains. During the expulsive stage, the cries of the woman are greatly suppressed, she holds her breath, and makes a bearing-down effort and cries out at the termination instead of at the commencement of the pain, as is the case in the preceding stage. The holding of breath and closure of the glottis fixes the thorax, by which means the abdominal muscles, having a fixed support, are enabled to compress the abdomen, and thus not only is a support given to the uterus, but it is actually compressed, and its own efforts supplemented in the expulsion of its contents. Holding the breath causes suffusion, congestion of the venous side of the circulation, as in persons in violent exercise. The face is swollen, and perspiration covers it and the body generally. These are the outward manifestations of the "bearing pains." But there are other phenomena. The pulse rises during a pain at the rate of three to five beats per minute, and the occurrence of a pain can be told by the pulse only. But the general rapidity of the pulse is not increased, as a rule, much during the expulsive stage. Indeed, very often the pulse is rapid during the dilatation stage, but when the os is fully dilated it subsides to the normal standard. There is one point connected with the expulsive stage which is very characteristic, viz., pain in the back. Pain in the abdomen is a symptom of the dilatation stage. The cause of the pain in the back varies; you can generally tell the situation of the affected organ by the position of the pain with its situation. If there is a fissured rectum, the pain is at the lower part of the sacrum. If the os uteri is in trouble, as in the dilatation, the pain is at the middle of the sacrum. If the pain be in the loins, the cause may be due to the kidneys, or transverse colon. If in the middle of the back between the shoulders, the cause may be stomach troubles. In the present case, as the head is passing through the os uteri, the pain is at the middle and upper part of the sacrum, but soon the head gets gradually pushed down and emerges from the vulva, the perinæum is stretched over it and protruded before the head of the child, the forehead sweeps forward, and the whole face by degrees becomes external, very often the jaw is open, and the edge of the perinæum passes into the opened mouth. When the head has escaped, a short interval of from about two to five minutes occurs; then a slight pain presses out the shoulders and arms, and the rest of the child down to the pelvis generally, but sometimes the whole child is expelled; and indeed the expulsion of the placenta occasionally accompanies that of the child. Generally the legs of the child remain in the vulva. Sometimes a much longer interval than five minutes precedes the birth of the body. In languid conditions of the uterus it is sometimes ten minutes, and where the shoulders are broad and fill the vagina tightly, there are many pains necessary to expel it. Indeed, in this case, the chest is so compressed, and the funis also, that the child succumbs, being unable to breathe, similar to the Chinese punishment of burying alive. The tightness of the vagina is so great that the attendant hesitates to abstract quickly, lest he should rupture the perinæum, of which, indeed, he may be afraid, for often it may happen that the head has passed the vulva, and yet the shoulders may cause rupture, by their soft parts overlapping the edge of the perinæum.

Report of a Case.

LACERATED WOUND OF THE KNEE-JOINT. RECOVERY.

I. C., æt. 22, a country labourer, was admitted into Accident Ward, under Mr. Bryant's care, on Oct. 20, 1873. He stated that he was standing on the shaft of his waggon when his foot slipped and he fell, striking his left knee against the waggon-wheel.

On admission, there was a contused lacerated wound over the anterior and inner aspect of the left knee; the joint was laid open so that the finger could be passed into it on the inner side of the patella. The joint was well syringed out with carbolic lotion (1 in 30) and the wounddressed with lint soaked in carbolic lotion (1 in 40). Ice-bags were applied, and the limb put upon a long back-splint. Pil Opii. 1 gr. every six hours was ordered. Patient to be fed with milk, beef-tea and brandy.

Oct. 22. Suppuration began in the joint. Patient was delirious; tongue dry and furred. Morning, temp. 104, pulse 136; evening, temp. 104·5, pulse 118.

From this time until the end of November there was a purulent discharge from the joint. The treatment consisted in thorough syringing of the joint with permanganate of potash lotion, cold water dressing, the application of an ice-bag, hypodermic injection of morphia night and morning to relieve the pain, and careful feeding. The temperature continued excessively high, running up every night to 103 F. to 103·5 F.

On Nov. 20, Quiniæ Sulph. 5 gr. three times a day was ordered, with the hope of bringing down the temperature; this failed, and on

Nov. 26, evening, temperature was 104·4 F., pulse 122.

Nov. 27. Tinct. Aconiti 10m. om. nocti was ordered. This acted almost like a charm, for the temperature taken two hours after the first dose was 102·2 F., and pulse 100. The aconite was continued until Dec. 11, the temperature never during this time rising above 101·5 F., excepting on two occasions, when the evening temperature was 102·2 F. After the remedy was discontinued there was no further rise of temperature until the patient became convalescent.

Dec. 22. The wound was nearly healed, no discharge from the joint. Evening, temp. 99·3, pulse 84. After this the patient went on very well, and on Jan. 13th, the splint was taken off. The knee was firmly anchylosed, so that the patient was able to raise the leg in bed without assistance. Fluctuation was now discovered on the outer side of the joint; a free incision was made, and a large quantity of dirty pus was let out. Pus was discharged from this opening until the beginning of February, when the discharge ceased, and the wound healed up.

March 5. The wound over the front of the knee had healed up. The splint was left off altogether. Patient was able to stand, but not without assistance. In a fortnight later, the patient could walk down the ward without assistance. The leg was then put up in a Bavarian splint, and the patient was sent to a convalescent home. Three months later he came to the hospital; the leg, though stiff, was very useful to him, and he was able to go back to his usual employment.

Operations.

FRIDAY, NOV. 13.

Mr. Bryant removed, by the ordinary method, a cancerous testicle. He remarked that the appearance of the growth on section was typical of soft cancer, or fungus hæmatodes, as it would have been called a short time ago. The older parts of the growth were undergoing fatty degeneration.

Mr. Durham amputated the left breast of a woman suffering from carcinoma. The usual incisions having been made, and the bleeding stopped, the wound was prolonged into the axilla and some enlarged glands removed. The axiliary vessels and the ultimate divisions of the brachial pexus were exposed at this part of the operation. An incision over the lower part of the posterior triangle was then made in order that an enlarged gland might be removed. Chloroform was administered during the greater part of the operation; the patient, however, growing cold and exhausted, ether was given with marked benefit.

Mr. Howse excised a knee-joint, which had twice before been tapped. Paraffin was afterwards used in padding the splint and fixing the leg. The bone on section was rather pale, but the opposed surfaces of the resection seemed perfectly healthy.

SATURDAY, NOV. 14.

Mr. Bryant operated for harelip in Lydia Ward in the following manner: On the left side the margin of the fissure was pared, and also the edge of the lip on the under surface, and thus a right-angled raw edge was made; on the right side the part of the lip forming the edge of the fissure was separated, but left attached at its lower margin. When this projecting tongue was pulled down a concave right-angled wound was made, and into this the convex right-angled raw surface was fitted, forming a very pretty lip.

Obstetrics.

MATERNITY CHARITY.

Statistical Report for the month of October :—Number of women confined, 190. Single births, 187; double births 3. Number of children born, 193. Of the presentations, 185 were vertex, 2 were face, 2 were foot, 1 was breech, 1 was arm, 1 was hand with knee, and one abortion.

Of the three cases of twins, the first child in two cases was vertex presentation; in one, the second child was also vertex, whilst in the other the arm presented. In the third case the first child was a breech, the second being a vertex.

The long forceps was used twice;—1. Inertia of the uterus, the head resting on the brim, the patient being in her eleventh confinement; 2. Rigidity of the perinæum in a primipara, the patient becoming exhausted.

The short forceps would have answered in the second case, but in the first they would not have reached the head, nor would their curve have suited that of the sacrum, and as the long forceps answers equally, wherever the head may be, it is useless to accustom oneself to more than one instrument.

The Surgery.

URETHRAL CALCULUS.—This occurred in a boy, aged seven years. The mother gave the following history:—For the last four years the boy has suffered from violent pains in the abdomen, which generally come on in severe paroxysms. Vomiting has been frequent, especially of late. He has been in the habit of constantly passing his water; no blood noticed in urine; and since last Sunday (Nov. 16th) the urethra has been the seat of pain and irritation. The bowels were often extruded when a child, but this has ceased for two or three years. On admission, the prepuce was long, but this was easily drawn over the glans penis, and then a foreign body could be seen just within the meatus. Dressing forceps failed to enter the urethra, but on gradually pressing the urethra behind the "body," the latter soon came away, bounding out; about one drop of blood escaped. On examining the "body" it was found to be a stone, probably consisting of lithic acid, the stone was oat-shaped, and measured five-eighths of an inch in circumference, and three-eighths of an inch in length. The boy, as far as could be ascertained, has not had retention of urine.

RUPTURE OF THE BICEPS MUSCLE.—The patient was a man, aged 21. The accident was caused by the falling of a plank of deal, 14ft. by 13ft., and 3in. in thickness, on the anterior surface of the arm. The arm presented a well-marked depression, about half an inch wide and half an inch deep, when the fore-arm was flexed at a right angle; but the depression gradually disappeared, as the fore-arm was more fully flexed, or when it was extended, but this was especially noticed in the former position. The rent was situated about three inches above the elbow. The power of flexing the fore-arm was diminished. The fore-arm was flexed and bandaged firmly. This man also had a bursa, measuring two inches by two inches, opposite the seventh cervical vertebra. He is in the habit of resting his planks on this spot, and he mentioned that his "mates" had similar tumours.

We understand, on good authority, that the second edition of Bryant's "Surgery" will not be ready until next October.

At the Royal College of Surgeons, this week, the following gentlemen were successful in the pass examination for the Membership:—Monday—Messrs. Brummitt, L.S.A., Powell, L.S.A., Seymour, Whitworth. Tuesday—Messrs. J. Carey, Eastall, L.S.A., Thomas, Tomlin, L.S.A. Wednesday—Messrs. Ferrier, Gibb, Piggott, Smith, L.S.A., Johnston. Thursday—Messrs. Blackmore, Dennis, Ockenden.

THE INDIVIDUAL AND HIS LANGUAGE.

Mr. Tegetmeier, the very highest authority on such a subject, told me, the other day, he had obtained evidence amounting almost to proof, that the variations of animals under domestication occur in such limited directions that they only obtain characters like the characters of allied species. So that what appears to be spontaneous in the individual and to be his own peculiar property and product, is really only his share of a common stock of endowments whose origin is lost sight of. Before he told me that, the limits of my own resources, and, lest I seem too much to depend on myself, may I add the conversation of my friends, had led me to a parallel conclusion; for I had come to think the primitive freshness of the little shoots that now and then show a fellow is alive, is mostly belied by the more or less evident truth that identical little shoots have very much sprouted before.

Now, don't let us at once say, "There is nothing new under the sun?" since that was first said, crowds of new ones, more or less not quite of the old sort, have appeared, and the question is, how so much newness is contained in the general oldness. Evidently it is much more easy to turn out more copies than to make fresh patterns, and Mr. Tegetmeier's observation would seem to show that Nature, whose dominant sense appears to be that of least resistance, discovered the ease of repetition long before man learned to play the part of second-hand providence, in saving originality by machinery. Such saving of originality by machinery is affected just now on an immense scale. Indeed nearly everything you touch has a wholesale machine-made style, your boots have machine-made uppers, the cakes are Huntley and Palmer's. Even the sentences of your friend's conversation seem to have come to him ready-made from Mudie's, just like Volckmann's sweets to the confectioner, or Crosse and Blackwell's pickles to the oilman. But that only in passing, what I am driving at is not the effect of human machinery, of novels, or steam-engines, but the nature-growth aspect of mental produce as expressed in language.

Does it not seem curious to you the way in which language has got you, so that the power of words lays hold on every recognizable point in your many-sided and much-fretted nature, and anyone who can rightly bring the proper words into play will wake up the images in your chambers of imagery like the music of Orpheus woke the surrounding botanical and mineral substances, until you let it be said that the stones cry out, and the hills be joyful, and the trees clap hands.

How in the the world did words get such a hold on your nature, so that you are at the mercy of whoever can drag you by them well and skilfully, and have to suffer much from the clumsy twitches of feebler performers, until you long to sever the communicating threads, or wish the pentecostal miracle could be reversed, that terms wholly foreign might not drag harshly your mental connexions.

It is worth while to trace this outside influence to its source. Watch a baby, and you will find its first sign of rational life is the conscious application of a word by which some simple object is called. It points to the eyes in pictures of animals and says "eye! eye!" and more than that, it looks to you for recognition of its cleverness, and expects you to look pleased and say "eye" too. And so far as its intellectual life is concerned, the baby will go on through childhood and youth and adult age doing just the same; observing and looking for signs that others make the same observations; and so far as its social life is concerned, trying to make as much as it can by the observations of itself and friends.

Please take notice that the perception of the eye in our example is the baby's own, but the proper sign of the perception it has to learn from others. And it will go on making its own observations of simple things and borrowing a name for each, and its friends will lend to it these names always with pleasure enough. And to the child the perceptions it has conceived of the things it has seen and felt are very real, and its names correspond to realities. So far so good. But as the baby goes on, his friends begin to make him take words into him, whose meanings are more or less outside the experience altogether. One degree of this foreignness is very simple, as when he hears of things and places he never saw. All one's life how much of the meanings of most words are thus outside one; he that has never seen the Himalayas or Amboyna has a conception of these, how different from that of the traveller just arrived from either. But it is not *things* he has not seen, but feelings he has never felt, and relations he has never entered, whose names come to him. Well, you say, but if he has no experience of these, they won't influence him. Stay a bit, the fact is different, for though he has never felt the feelings or entered the relations, yet he perceives and hears of their effects on others, and so at second-hand has vague notions of meanings outside him.

Now, cannot you see that the word is the *fulcrum* F, the meaning is the *power* P, and stupidity or ignorance is the *resistance* W. And when our youngster, or older person for that matter, is placed so that P the meaning is outside, F the word is in his ear, and W the ignorance is in his brain, he is so far at the mercy of the outer world; and in fact he is in exactly the opposite box to the more fortunate circumstances in which the meaning is inside, the ignorance in his friends, and words for fulcrums are plentiful to turn his friends round and round.

But yet another higher step; are there not words which, in the way I have indicated, get planted in each individual in succession by those outside, and yet whose meanings are unknown by any? never were known by anyone? Words whose meanings are not for the individual at all, except to awe him with sense of power beyond individual scope. Articulate expressions of dominions that influence all and are within the scope of none. By which the race claims and controls each of its individuals. And the capacity and tendency of each individual to be penetrated by and to share the import of these race-words form his loyalty and religion, and give proof that the individual is "*true to kind.*" How, then, about the individual and his language? You see that of every race there is a deal in its language that is too much for the individual; puts him, as it were, on the short arm of a lever. And as a corollary, it is true that if a man desire to keep his intellect within his own power he can do so in two ways; one is to learn to be callous to meanings that are outside him. The other is to comprehend all meanings within him. The first will make him secure, but an insensitive blockhead; to achieve the second is the promising aim of "self-development." To perceive the baseness of the first, and the impossibility of the second, so as to accord to those outside a proper and just esteem, is the modest side of true gentility.

Pilocereus Senilis.

Out-patient Room.

Abscess at or near the posterior border of the sterno-mastoid is frequently due to impetigo of the scalp, which in turn is caused by pediculi.

You may recognize a healing ulcer if you see externally a white line of new skin, and within this a bordering of a purplish colour, which is new skin in process of formation.

Syphilitic maculæ, as they approach the mucous membrane, or skin allied to it, gradually develope into condylomata.

Gummata in the nose are often unsuspected; though they are very frequently found as the result of specific action.

Firm and equable bandaging often does much good in cases of talipes in young children, when persisted in for a sufficient length of time.

Rhubarb frequently has a good effect in cases of spasmodic asthma—probably from the frequent dependence of asthma on dyspepsia.

Whenever you have a case of chronic dyspepsia, without evident cause, more especially in women, always keep in mind the possibility of its dependence upon intemperance.

Copaiba is often of great use in dropsies, as a diuretic.

A blister frequently relieves the pain in aneurism, if applied immediately over its situation.

Colchicum is often effectual in the pain so often and so long felt after shingles.

Correspondence.

To the Editors.

Sirs,—From the number of notices which have been posted up in various parts of the Hospital, I am led to conclude that a very considerable number of umbrellas, books, &c., have disappeared, under circumstances rather unfavourable to the general character which our hospital has borne hitherto. I had thought that, possibly, in the majority of cases, the owner might have mislaid the missing article, but on enquiry found that there was not the least doubt but that it had been wilfully taken away by some person, and, what is more, had not been returned, or even the slightest notice taken of a request made in writing and posted in different places by the owner in order to recover it. Probably, had it not been that I am a personal sufferer, I should not have troubled you with a letter on the subject; the facts of my own case are as follows:—I attended Mr. Davies-Colley's Class on Surgery, and by mistake left a Gray's "Anatomy" in the room opposite the library, and on returning an hour afterwards I found it gone. I have made enquiries of every one who is in any way connected with the room, but to no avail, so that I am compelled to ask you to insert this letter, thinking that possibly I may have it restored; my name was inside, so that the gentleman who borrowed it (to use a mild term) could easily return it. Apologizing for intruding on your valuable space,

I am, Sirs,
Yours, &c.,
J. H.

P.S.—Should the gentleman who has my book have taken it with a view of selling it, I shall be most happy to give him 5*s.* on its being returned.

[These petty thefts are common at all large institutions. We insert our correspondent's letter to warn our fellow-students of the danger of leaving their property unprotected. Where there are between three and four hundred students, any respectably-dressed pick-pocket may pass the gate-keepers unobserved, and help himself to any umbrellas or books which may be left unguarded.—Ed. *G. H. G.*]

Sports.

FOOTBALL.

Guy's v. St. Thomas's.

This match came off last Saturday. Play commenced very late, and we were one man short. Up to half-time nothing much of interest occurred, play being very equal; after half-time Guy's had to play down hill, Mackern made two good runs, and nearly succeeded in getting in once. Darker made one or two good runs for St. Thomas's. Play was terminated ten minutes before the time was up on account of darkness.

LONDON UNIVERSITY.

Second M.B. Pass Examination.—1874.

Monday, Nov. 2.—Morning, 10 to 1.

Obstetric Medicine.

Examiners: Robert Barnes, Esq., M.D., and Professor Graily Hewett, M.D.

1. Give an account of the Passage of the Head through the Parturient Canal in the "First Position."
2. Describe the forms and varieties of Post-parum Hæmorrhage.
3. Give the Diagnosis and Treatment of Prolapse of the Funis.
4. What are the Signs by which you would recognise the presence of Uterine Inertia in the first, second, and third Stages of Labour, respectively?
5. What are the principal causes of Hæmorrhage from the Uterus, excluding Pregnancy and its effects?
6. Describe the Uterine Sound; show the uses of the nstrument; point out the dangers which may be incurred n using it; and state what Precautions you would adopt n order to avoid them.

Monday, Nov. 2.—Afternoon, 3 to 6.

General Pathology, &c.

Examiners: J. Syer Bristowe, Esq., M.D., and Professor Wilson Fox, M.D., F.R.S.

1. What do you understand by the expression "a Typhoid State?" Describe its characteristic features, and explain its origin and nature.
2. What agents are efficacious in the reduction of Temperature of the Body in Fever? and what is the *rational* of their respective modes of action?
3. Describe in detail the measures to be adopted for the purpose of Preventing the Spread of Infectious Febrile Diseases.
4. Describe the modes of origin and the structural changes characterizing the different forms of Softening of the Brain in their various stages.
5. What evidence exists respecting the probable mode of action of Digitalis on the Vascular System? Describe the therapeutical uses of this drug, and the indications for its employment.
6. Describe the Pathological consequences resulting from the overcrowding of a population in their dwelling-houses.

Tuesday, Nov. 3.—Morning, 10 to 1.

Surgery.

Examiners: Professor Marshall, F.R.S., and W. S. Savory, Esq., M.B., F.R.S.

1. Describe the local signs and general symptoms of Erysipelas following a Wound,—its course to a favourable or fatal issue,—and the treatment you would adopt in its various stages.
2. Describe in detail your management of a case of Simple Incised Wound of the Knee-joint in a healthy person. State the various unfavourable consequences which may arise, and the way in which you would meet them.
3. Give an account of the conditions under which you would deem it right to Puncture the Urinary Bladder. Point out the advantages and disadvantages of the various kinds of operation required for that purpose. Describe in detail any one of those operations.

Tuesday, Nov. 3.—Afternoon, 3 to 6.

Medicine.

Examiners: J. Syer Bristowe, Esq., M.D., and Professor Wilson Fox, M.D., F.R.S.

1. Describe the diagnostic criteria between Cancer and Ulcer of the Stomach, and state the elements of prognosis in each of these diseases respectively.

2. Describe the symptoms of Glycosuria, and give the evidence in favour of the different methods of treatment proposed for its cure.

3. Describe the clinical symptoms of the Disorders of the Nervous System which are observed as secondary consequences of Diphtheria. State their prognostic significance, and mention their appropriate treatment.

4. Give a clinical history of Rötheln or Epidemic Roseola, and show in what points it resembles, and in what it differs from, Measles, Scarlet Fever, Small-pox, and Typhus.

5. How do you distinguish between Pectoriloquy, Bronchophony, and Œgophony? How are they supposed severally to be produced, and what do they severally indicate?

6. What is a Floating Kidney? What are the symptoms to which it may give rise? What are the affections with which it may be confounded? and how would you distinguish between it and them?

Wednesday, Nov. 4.—Morning, 10 to 1.

Forensic Medicine.

Examiners: Professor Gamgee, M.D., F.R.S., and Professor Maudsley, M.D.

1. If requested to examine a woman alleged to have been recently delivered, to what points would you direct your attention?

2. How would you conduct a complete physical and chemical examination of suspected Blood-stains?

3. Contrast the symptoms which are generally induced by large poisonous doses of Arsenious Acid, Oxalic Acid, and Corrosive Sublimate; and state the treatment which you would adopt in each case.

4. Describe the differences between—(*a*) Wounds inflicted during life, and after death; (*b*) Scalds inflicted during life, and after death.

5. Describe the symptoms and treatment of poisoning by Hydrocyanic Acid, and the means of its detection in the body after death.

6. Write a Certificate of Insanity in accordance with the Statutory form, pointing out what precautions it is necessary to observe in order that it may be legally valid.

ROYAL COLLEGE OF SURGEONS.

The following paper was set during the week at the pass examination for the diploma of member:—

Examination on the Principles and Practice of Medicine.

1. A patient is taken more or less suddenly ill, and is seen after four or five days have elapsed, and is then found much prostrated, with a furred tongue, quick pulse, hot skin, and other symptoms of fever. What are the diseases on which the symptoms may depend? and how would you severally distinguish them?

2. What are the different causes which may give rise to vomiting and spitting of blood? how would you distinguish them? and what treatment would you adopt in each.

3. What are the chief preparations in the British Pharmacopœia into which Opium and Morphia enter? State the proportions of the several ingredients in each, the doses in which the different preparations should be given, and the purposes for which they are severally more particularly adapted.

Write a prescription for an anodyne draught, and for a mixture to check sickness and vomiting.

Examination on Surgical Anatomy and the Principles and Practice of Surgery.

1. Give the diagnosis, the anatomical and pathological characters, and the treatment of Adenoid tumours of the Breast.

2. Describe what is meant by angular curvature of the Spine; and what are the local changes which precede and accompany it?

3. Describe the Femoral ring; and mention the parts exposed to injury in the operation for Femoral Hernia.

4. How is Hæmorrhage arrested spontaneously, in a partially divided, a completely divided, and a torn artery?

5. At what parts of the Lachrymal passages may obstructions occur? State what are the symptoms and treatment of such obstructions.

6. Describe the operation of tying the Brachial Artery in the middle of the arm.

The Wards.

MEDICAL.

The following Cases were admitted between Nov. 11 and Nov. 18:—

ADDISON.—6—Syphilis. 10—Mitral regurgitation. 17—Cynanche. 25—Albuminuria. 35—Acute rheumatism. Cot—Pneumonia, right upper lobe.

BRIGHT.—5—Pleurisy. 16—Phthisis. 20—Acute rheumatism. 21—Chorea. 23—Acute rheumatism.

PHILIP.—7—Morbus cordis. 21—Acute rheumatism. 22—Chronic rheumatism. 31—Strumous ophthalmia. 41—Erysipelas of face.

MIRIAM.—23—Pleurisy (?). 24—Enterica. 27—Glossitis.

JOHN.—No admissions.

STEPHEN.—1—Tubular nephritis. 10—Acute bronchitis. 19—Acute rheumatism—systolic aortic bruit. 20—Double pleurisy—enlarged spleen—purpura, &c. 24—Cephalalgia. 46—Acute rheumatism.

MARY.—7—Albuminuria. 8—Acute rheumatism—systolic apex bruit. 9—Acute rheumatism—double pneumonia. 17—Neuralgia. 20—Pelvic tumour.

SURGICAL.

The following cases were admitted between Nov. 11 and Nov. 18:—

ACCIDENT.—8—Fracture of the tibia and fibula. 10—Fractured tibia and fibula. 14—Concussion. 16—Concussion. 17—Scalp wound. 21—Injury to hip. 29—Concussion of spine. 32—Fractured tibia and fibula.

CORNELIUS.—No admissions.

JOB.—3—Acute aneurism. 8—Fistula in ano. 9—Epitheloma of tongue. 11—Stricture. 13—Wasting after amputation of thigh. 19—Bleeding from femoral artery. 21—Cleft palate.—22—Acute synovitis.

LAZARUS.—11—Wound of arm—division of musculo-spiral nerve.

MARTHA.—14—Catarrhal inflammation of frontal sinuses.

CHARITY.—No admissions.

DORCAS.—Bursitis patellæ. 12—Sinuses about heel. 13—Fistula in ano. 22—Necrosis of phalanx.

LUKE.—No admissions.

LYDIA.—16—Cut throat. 18—Fracture of fibula. 19—Wound of vulva. 23—Eczema.

NAAMAN.—1—Necrosis of os calcis. 3—Elephas. 6—Extravasation of urine. 11—Scrofulous ulceration. 12—Fistula in ano. 18—Acute synovitis.

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Printed for the Presidents of the Physical Society by ORLANDO G. BRIMMER, of 104, Borough, S.E

Guy's

Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 9. SATURDAY, NOVEMBER 28, 1874. TWOPENCE

IT is a tolerably well-known fact that bodily exercise is not incompatible with mental improvement, indeed, some go so far as to say that the one goes hand in hand with the other. If this latter statement be true, we cannot augur well for the future success in the College Examinations of the Members of the Second Football Fifteen. If we have any influence with these gentlemen, we would urge them to look to their laurels.

It is not, we are sure, that the hospital is deficient in talent, but that, like modern Cæsars, they prefer to play in the First Fifteen of Foreign teams than in the Second Fifteen of their own Schools. This is not as it should be, for there is no one who may not by steady play work his way in the first. And surely there is, or ought to be, more zeal in this prospect than where there is no hope of such advancement. We would ask, then, those men who forsake their hospital for other clubs, to think a little of the glory of their School. We would not, for a moment, believe the scandal that some men refuse to play in the Second because they think themselves worthy of the First Fifteen, but we do think that from so large a number of men as there are at Guy's, two complete Fifteens might be put into the field if every football man would make a *little* effort.

THE new edition of Tanner's "Medicine," revised by Dr. Broadbent is now ready. The original style has been preserved, but many important additions have been made, notably in the appendix, a section by Dr. Coombs on "Electro-Therapeutics." A section on "Syphilitic Affections" has been added, and that part devoted to "Heart Disease" has been improved, and especially with respect to "Mitral Stenosis." The review of this work by the *Lancet* is highly satisfactory.

A STRANGE case of Post Partum Hæmorrhage is given in last week's *Lancet*. Labour was premature at seven months; after birth, the uterus retained its normal dimensions and labour continued. Presently the membranes approached the outlet, and on being ruptured "a great rush of hæmorrhage" occurred instead of the waters of a second child, as had been expected.

MR. MONTEVERT has written a monogram on an easy and certain means of demonstrating the reality of death. It consists in the injection of a few drops of ammonia beneath the skin; if the subject be dead, the spot produced is scarcely different from that of the skin, whilst if it be alive, the spot "is always of a more or less vinous red."

Lectures on Midwifery.

By J. BRAXTON HICKS, M.D., F.R.S.
Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

LECTURE V.

As the head escapes a sudden increase of pain is experienced, causing the patient to cry out vigorously, so

that the power of the auxiliary forces may be lessened; and thus instead of the head being violently expelled, it is gently extruded.

If the labour be very severe, cramps are frequently experienced; caused, no doubt, by the pressure of the head on the sacral plexus. When in a difficult labour very little apparent progress is made, but cramps are complained of, it is almost always a symptom of real progress.

After the birth of the child a clot or two may be expelled, but the uterus should be quite firm, in a state of contraction, the placenta being retained in its cavity. There ought not to be more than half a pint of blood lost at this period.

Duration of Labour.—The preparatory stage may last for many days, without detriment to the patient. The first, or dilatation stage may last for twenty-four hours, without being considered long. While the membranes remain unruptured, and the os not fully dilated, it may last for two or three days without harm, especially if pains are very slight, but the case must be closely watched, and if the pulse rise there is danger. It is very different, however, with the expulsive stage. In multiparæ without obstruction it seldom lasts more than three or four hours; in primiparæ usually longer. If arrest takes place during the expulsive stage, then danger is apt to arise. Should there be none, or very slight progress for three or four hours, with average pains, it is desirable that some assistance be afforded the patient. The nearer the head approaches the outlet, the more important is detention to the patient.

Phenomena of a Labour Pain in Dilatation Stage.—Peristaltic wave.—1. Contraction of os, and (2) recession of presenting part. 3. Contraction of fundus, and (4) relaxation of os uteri, and (5) protrusion of presenting part. 6. Rise of pulse three to five beats per minute. 7. Slight bearing-down pains. 8. Abdominal or uterine pain.

Expulsive Stage.—1. Pains forcing, auxiliary assisting more or less powerfully; causing suffusion of face, and sweating. 2. Pain felt in back. 3. Wave of pain as before; the presenting part slightly receding on subsidence of pain. 4. Pulse rises during a pain rather more than in in the dilatation stage.

After the birth of the child, the expulsion of the placenta has to be accomplished. This is done by exactly the same forces as have previously been in action to expel the child. Five or ten, or even thirty minutes may elapse before the uterus again commences to contract, in order to expel the placenta.

During the whole of this period, however, the uterus ought to be in a state of tolerably firm contraction; not in a state of passiveness. This action is due partly to the presence of the placenta, but mainly to the irritation set up and remaining in the parturient passages, by the pressure of the child's head. If the child slip through easily, the reflex irritation set up is very slight, lasts only for a short time, and then passes off; and if the placenta be in the slightest degree detached the patient is liable to hæmorrhage.

After a slight pause, then, of five or ten minutes, the uterus resumes its activity; the patient generally complains of a renewal of pains; the placenta is detached, and extruded into the vagina. Generally a slight quantity of blood accompanies this process. This should never exceed half a pint. To gently draw away the placenta from the vagina completes the delivery.

This, the supplementary stage, or the expulsion of the placenta, is the most dangerous to the woman; and demands more care on your part than the expulsion of the the fœtus.

The mode in which the placenta is expelled is a much disputed point. How is the placenta detached? You are aware it is of considerable size. The area to which it was attached in the fully distended uterus is much lessened, the placental size is nearly the same: by the contraction of the uterus, therefore, it is detached in all directions. If it be implanted on the side of the uterus, it is folded up lengthways something like a roll of paper, the funis hanging out at one end of the roll, so that when you examine you will find the lower margin first, and passing the finger round inside the os uteri you will find the edge of course higher up but following the course of the uterus. As it is expelled the form is very plainly marked. If, however, the placenta is at the fundus, and the funis has been pulled at, then the placenta and membranes are turned inside out, and the amnial surface, with the funis insertion, comes first. This often causes a collection of blood behind the placenta.

Management of Natural Labour.—The mode of entering a lying-in-room is of the utmost importance, especially to young beginners. Never, unless urgently sent for, go up from the door into the sick chamber at once. Always send up notice of your arrival. If you run up brusquely you may find the pains completely cease, perhaps for half a day. If you are a young hand do not go up into the sick room before you have sent for the nurse and asked her some questions as to the state of the case, &c. Enter the room with a cheerful face, quietly. What you want to ascertain first, is the stage of labour the patient is in; and this you can partly tell by the character of the cry. Then you want to know whether "the waters have broken." The rule is to examine as early as possible. In asking for an examination in the case of the better classes, it is perhaps better to do it through the nurse. This is hardly necessary among the poorer classes. The examination is commonly called "trying a pain," and what you want to see is whether the child is naturally presenting, or as it is called, "right for the world." The examination is conducted as follows:—Let the patient lay upon her left side, in the English obstetric position; and, having anointed one or two fingers with cold cream or lard pass them into the vagina, and seek for the os uteri. The best way is to pass the fingers along the vaginal wall, and not to run them straight up to the os, for fear of rupturing the membranes. All this time the patient must be covered up—all examinations and manipulations being conducted, as far as possible, without exposure. Now, what do we learn by an examination? A great deal. 1st. Whether the patient be really pregnant. 2nd. Whether she be really in labour. A woman may be in very severe pain, and uterine pain too, and yet not be in labour. 3rd. You ascertain the stage of the labour. It is easy to make out whether the os is dilated or not. 4th. You ascertain the presentation. This is very important; because, for instance, if it be a transverse presentation, the rupture of the membranes drives down the child, and we have a difficulty to encounter; therefore ascertain the presentation as early as possible, in order to rectify mal-presentations. If the head present, you may be able to find out in what position it is placed. It is of great advantage to know whether the occiput is anterior or posterior; but not of much consequence whether it is right or left. Then you may notice the size of the child's head. It may be hydrocephalic. Also the size of the patient's pelvis. With your two fingers it is very easy to ascertain whether you can reach the promontory of the sacrum; if not, you may be certain the pelvis is not abnormally small in the brim. Then just sweep your fingers round to see that there

are no outgrowths from the pelvic walls. Head presentation is usually made out easily, not through the membranes only, but also through the anterior wall of the cervix. In examining you ought to be able to feel the head during the interval through the flaccid membranes. If you can detect no presentation, you may generally assume the child is wrongly placed, most probably transversely; or that the liquor amnii is in excess. Having conducted the examination, and found everything satisfactory, you may inform the patient that everything is proceeding straightforwardly, and that there is no cause for anxiety. After this, supposing the waters have not ruptured, do not examine for some time; but as soon as they have escaped you ought to examine again. Do not hold out hopes of speedy delivery to the patient. If you do she is very liable to get alarmed if it is not soon over. If the labour is only just commencing it is better to tell her that it will not be over for some time.

Suppose labour has fairly begun, what is the best position for the woman to be in? In the early stages, till full dilatation, she may assume the recumbent position, unless she wishes to walk about for a time. In the very late stages she should be kept in bed; in the middle stage mainly recumbent, but may move about at intervals as she likes. As regards the diet, give her plain diet, and as much as she can fairly eat. In he early stage a mutton chop may be taken, but do no give much stimulants. Attend to the state of the bowels It is a great comfort to have them well opened before labour, or, if this has not been done, as early as possible after commencement. A dose of castor oil, or perhaps still better, an enema may be given. Ascertain that she passes her water. It sometimes, though rarely, happens in natural labour, that the water is retained, and requires to be drawn off by a catheter. The room must be kept moderately cool, as far as is consistent with the patient's exposed state. There are certain things you must have ready at the time. The "receiver"—a petticoat or blanket to receive the child when born; some tape or firm string, for securing the funis; scissors, pins, and a "binder"—the latter may consist of a towel or piece of calico, of sufficient length to fally cover the uterus, and to pin across by a good overlapping margin. There are conflicting opinions as to the use of the binder—some neglecting it as useless, and others putting great faith in its assisting the uterus to contract. No doubt it assists the auxilliary forces to support the uterus, and by downward pressure increases the reflex irritation and stimulates pain. Then you must see that the bed is prepared. It should have a piece of leather mackintosh, floor-cloth, or American-cloth, placed first, large enough to reach to the middle of the patient's body, over this a blanket is spread, on which the patient lies. Cold water should be at hand, in case of sudden hæmorrhage, also ice, especially in patients liable to floodings.

Having ascertained all to be right, it is as well to go out of the room, unless labour be impending. It is not always necessary even to stop in the house. If the os be not dilated you need not, generally; but if it be, and you are a young practitioner, I should advise you not to leave the house. You had better err on the side of over-attention, than the contrary. Some cases terminate very rapidly after the dilatation process has begun; and blame will be thrown upon you if you are out of the way when the child is born. Few old practitioners leave the house mentally easy after dilatation has begun in a multipara.

Physical Society.

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At the last meeting of the Physical Society, held on Saturday, Novembsr 21st, Mr. Fry in the chair, a paper was read by Mr. Coley on "Gastric Ulcer."

Mr. Jumeaux, in opening the discussion, said he could not differ from Mr. Coley in many points. He thought ulcers of the stomach might reach to six inches in diameter, and that they were sometimes found irregular. Cancer was not always distinguished by any peculiar cachexia. If the theory advanced as to the origin of gastric ulcer were true, how did he account for there never being any ulcer in the stomach in such diseases as gout, cholera, or where the alkalimity of the blood was so greatly reduced?

Mr. Chicken called attention to the fact that the blood supply to the lesser curvature, was dependent upon smaller vassels than that to the greater. Would that account for the greater frequency of ulcers in the former position? In the case referred to by Mr. Coley, he (Mr. Chicken) had been called in for a violent attack of dyspnœa, which it was thought at first would necessitate tracheotomy, but which readily yielded to anti-hysterical remedies: was not this in favour of the symptoms of the supposed gastric ulcer being simulated?

Mr. Symonds asked if the gastric juice acted on the tissues in which stasis had taken place, why did it not produce immediate perforation? When perforation did occur, after adhesions had been formed to neighbouring organs, those organs were not found digested. The differential diagnosis from cancer was very important. In both, the pain and distress were similar, but in cancer you were almost certain to feel a lump. Mr. Symonds then gave an analysis of the cases of ulcer in the museum, the large majority occurring about the lesser curvature. Perforating ulcers of the stomach might be divided into two classes, those producing peritonitis, and therefore death, and those becoming adherent to neighbouring organs, life being prolonged.

Mr. Shadwell said, if disturbance of the circulation and stasis were the causes of the ulceration, why should there not be ulcers over a large extent as well as over such small areas. With regard to the diagnosis from hysteria, he had felt great difficulty in a case in Mary Ward. It was decided in favour of hysteria, on account of the patient's behaviour, her healthy appearance, and the diffuseness of the pain. In cases of hæmoptysis the patient sometimes swallowed the blood, and afterwards vomited it, this should be remembered in the diagnosis. Mr. Symonds might have added to his two classes a third, where there was cicatrization and no perforation.

Mr. Tyson remarked that in examining the cases in the museum, one could not help being struck with the number occurring at the lesser curvature in young people, and the suddenness of the fatal result. There were two causes of ulcer in adult life—intemperance and phthisis—where the symptoms went on for some time. He mentioned a case of an old woman in Petersham Ward, which terminated suddenly.

Mr. Green thought that with regard to the prognosis it was important to recognise the position of the ulcer. This might be done by noticing the position in which the patient lay most comfortably.

Mr. Creed described a case of gastric ulcer, which, on

account of the pain in the back, was taken for spinal disease.

Mr. LANCASTER thought that many cases of ulcer might be due to inflammation rather than congestion. Why did ulceration after burns take place in the stomach as well as in duodenum? He did not know why emboli should be so localized in their action, and asked whether emboli had been found in other parts of the body. He suggested that thrombosis was more likely to be the cause. Cancer might occur in parts where a tumour could not be felt. There seemed to be some connection between the stomach and the uterus, as the pain in ulcer was increased at the catamenial period.

Mr. DUKE said there seemed to be some analogy between gastric ulcer, and the ulcer of enterica. Ligature of the sympathetic in the neck produced ulcer of the cornea. Why should not irritation of the pneumogastric produce ulcer of the stomach?

Mr. JONES remarked that examination of the ulcer showed some active change, or whence the connective tissue thickening and compound granular cells, if active changes had not taken place. With regard to the blood supply, they must remember the very free anastomosis that took place between the arteries supplying the two curvatures. If embolism did occur, this free supply would probably prevent ulceration from gastric digestion.

Mr. MCCARTHY asked, might not the ulcer be traumatic? Any food eaten, as sharp pieces of crust, &c., before being acted upon, might produce enough wound to cause ulceration. Help in the diagnosis might be obtained by finding blood in the fœces when none had been vomited. He advised the administration of oil of turpentine.

Mr. SHADWELL acknowledged the great difficulty there was in diagnosis, but could hardly imagine how hæmatemesis could be simulated by hysterical patients. Patients could often keep down asses' milk when cows' milk was rejected.

After a vote of thanks to Mr. Coley, the meeting adjourned.

Report of a Case.

ANEURISM OF POPLITEAL ARTERY—INTRODUCTION OF HORSEHAIR INTO SAC—DEATH.

W. B., æt. 33, was admitted into Job Ward, under Mr. Bryant's care, on Oct. 20, 1873.

History.—Twelve years ago patient had acute rheumatism, since then he has been strong and able to work as a waterside labourer until seven months ago when he had another attack of rheumatism; since then he has never been well and strong. Seventeen days before admission he felt a sudden pain in his right foot soon after walking home. Soon after this he noticed a pulsating swelling in the calf of his right leg.

On admission, the upper part of the right leg was swollen, the veins were full and prominent, and the foot œdematous; at the lower part of the popliteal space was a large swelling, the pulsation could also be felt anteriorly between the tibia and fibula. The right leg measured 14⅝in. round, the left measured 11½in. On examining the chest it was found that patient had extensive heart disease; there were loud systolic mitral, and to and fro aortic bruits. Patient was left quiet in bed and morphia given for a few days.

On October 24th pressure was begun. This was kept on for twelve hours each day until Oct. 27. After this the lower part of the sac appeared to be rather firmer, otherwise there was no change in the condition of the aneurism.

Nov. 4—Pressure was again begun, but on

Nov. 6 patient could not bear it longer. The pressure was continued at intervals up to Nov. 17, in all it was kept up for 102 hours. At the end of this time the sac was increasing in size, so that this treatment was given up. The question now was what had best be done. Mr. Bryant believed that the artery higher up was diseased, and so ligature by the Hunterian operation was not suitable; he, therefore, decided to attempt to cure the aneurism by introducing horsehair into the sac. Flexion of the limb had been already tried, combined with the pressure.

Nov. 25—Mr. Bryant passed a trochar and canula into the sac; on withdrawing the trochar about 18ft. of horsehair was introduced into the sac, and the canula was then removed; the limb was wrapped up in cotton-wool, and the patient put back to bed. He continued comfortable for some hours, when he was seized with severe pains at the point of puncture. At 9 p.m., temp. 102·8, pulse 120. Morphia ⅓gr. subcutaneously was given.

Nov. 26—Rigors. Morning—Temp. 104, pulse 132; 3.30 p.m., temp. 405·5, pulse 132; 9 p.m., temp. 103.8, pulse 120.

Nov. 27—Patient was flushed and very feverish; the pulsation in the sac was somewhat less than before the operation. Morning—Temp. 105·8, pulse 120; evening—temp. 103·8, pulse 130.

Nov. 28—The patient gradually sank and died at 7·30 p.m.

P.M.—The superficial structures around the point of puncture were healthy, but beneath the gastrocnemius muscle the horsehair was protruding from the sac, and had started some suppuration in its neighbourhood. The aneurismal sac was found to involve the popliteal artery just at its bifurcation; on cutting into the sac it was found that fibrin had coagulated round the horsehair, and the aneurism was apparently cured. The other arteries were found to be quite healthy.

On examining the heart it was found that there was recent ulcerative endocarditis, and to this must be attributed the sudden termination of the case, rather than to any operative measures undertaken for the cure of the aneurism.

The Dissecting-room.

It is not until the November examinations of the Royal College of Surgeons are over, and the first six weeks of the session are passed, that the first and second years' men seem to settle into regular work. It is then that demonstrations commence, and second year's men recognize in these the beginning of the "great grind" for the April ordeal. The attendances at the demonstrations given last week and this, were so large, as hardly to allow of sitting-room in the small theatre in which they are given. This may be partly accounted for by curiosity, but we know from our own experience of last year, that these demonstrations have of late been much better attended than they were formerly. Classes also have been commenced for those gentlemen who intend to present themselves in January. During the past fortnight five subjects have been sent to us, but these were not enough to employ all hands waiting for "parts."

HIPPOPHAGY.

THE taste which our Parisian neighbours acquired for horse-flesh during the siege of their city, seems to have taken deep root, and to be still on the increase; for it is stated that no less than 1,555 horses, mules, and asses were slaughtered between June and September of the present year, whereas in the corresponding months of 1872 only 1,140 fell victims to the butcher's knife. We are told that the flesh of mules and asses, is more highly appreciated than that of horses, on account of greater tenderness and a more game-like flavour. Possibly it may not be inferior to the Australian meats which have lately been so severely condemned by an Epicurean writer in the *Saturday Review*. We are inclined, however, to agree with *Punch's* Dictionary, that Hippophagy signifies eating horse-flesh, and that to say eating horse-flesh is nice is Hypocrisy,

UNIVERSITY OF LONDON.

IN the Honours List of the Second M.B. Examination, the following gentlemen were of this Hospital :—Medicine—First Class—Mr. Thomas Eastes, third; Second Class—Mr. James A. Rigby, second. Obstetric Medicine—First Class—Mr. Thomas Eastes, third; second class—Mr. J. A. Rigby, first; Mr. H. S. Branfoot was also placed, he being equal with Mr. Crocker, of University. Forensic Medicine—Second class—Mr. Thomas Eastes was second.

THE GOVERNORS' DINNER.

THE Governors' Dinner was held in the Court-room of this hospital, on Wednesday last, the 25th inst., when, owing to the illness of the President, the chair was taken by the Treasurer. There were present, Lord Kirkaldy, Lord Coleridge, Sir William Gull, the Medical and Surgical Staff, and many distinguished members of Parliament.

THE EVELINA HOSPITAL.

WE understand that, at the meeting of the Medical Committee of the Evelina Hospital, held on Tuesday, the 24th inst., William E. Paley, M.R.C.S., L.R.C.P., was unanimously elected as the candidate to be recommended to the General Committee for the vacant House-Surgeoncy.

FELLOWSHIP OF THE ROYAL COLLEGE OF SURGEONS.

THE following gentlemen, students of this Hospital, were successful at the primary examination for the Fellowship held during the week :—Messrs. Amphlett, Carrington, John Morgan, and Pye-Smith.

IT is a subject of congratulation that Dr. Hardwicke was elected coroner for Central Middlesex in the place of the late Dr. Lankester. He was returned by a majority of 346 votes over Mr. James Boulton, the legal candidate for the appointment, who polled 818.

MR. TOM HOOD, Editor of *Fun* and son of the well-known poet, died on Friday, the 20th inst.

Operations.

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MONDAY, NOV. 16TH.

Mr. Forster cauterised two patches of lupus on the face of patients suffering from lupus non-exedens. This treatment has been followed by great benefit, and one case has been almost cured by its means.

TUESDAY, NOV. 17TH.

Mr. Colley performed Symes' amputation of the foot on a patient in Job Ward. The incisions were made in the usual manner, but some difficulty was caused by the culcanean artery having been divided by a former incision.

WEDNESDAY, NOV. 18TH.

Mr. Durham operated for ectropia vesicæ. In the middle line of the abdomen the red surface of the posterior wall of the bladder was seen. On each side of this an incision was made along two sides of an imaginary triangle, the base, situated near to the bladder, was left attached. The two flaps were now turned over and united at their anterior and lower edges, thus forming an anterior wall. In this operation the cuticle was turned inwards to form a mucus membrane, whilst the subcutaneous tissue was left external to cicatrise over and become skin. An indiarubber tube was introduced beneath the flaps, through a small opening, by which the urine might drain away.

THURSDAY, NOV. 19TH.

Mr. Durham removed dead bone from the upper part of the tibia. Mr. Durham remarked that caries more commonly affected the epiphyses of long bones than necrosis, whilst necrosis was more common in the shaft. In this case the disease was both caries and necrosis, and was removed with the chisel and cleaver.

FRIDAY, NOV. 20TH.

Mr. Howse excised a knee-joint. This was afterwards, in the ward, packed in a suitable splint, by means of paraffin and cotton. Bandages soaked in paraffin were afterwards applied. The whole of the operation was performed under the carbolic spray.

Late on Friday night, Mr. Durham operated for strangulated femoral hernia in Dorcas Ward. The bowel was enclosed and constricted by omentum, which had to be divided before the hernia could be reduced.

On Saturday night, Mr. Colley operated for strangulated femoral hernia. The usual incision was made, and a very small piece of bowel found to be strangulated. The sac was found to be filled with material like blood-clot, as though violent taxis had been used.

Obstetrics.

—o—

F. T., æt. 38. Has been married eight years. She has been pregnant but once (seven years ago) and then miscarried. Menstruation has always been regular, and somewhat profuse.

Last May she was unable to pass her water for a week; a catheter was passed, but since then she has had no difficulty. This is the only trouble she has had, with the exception of pain in the back.

The os uteri is felt high up behind the pubes, the whole pelvis being filled by a firm globular mass, which rests almost on the perinæum, and is very little moveable. The sound passes three and a-half inches almost directly backwards. Barnes' bags were introduced, but they caused much inconvenience, and did little service.

On the 9th the patient was placed in the knee-elbow position, and the tumour raised slightly by pressing it upwards and to one side of the sacral promontory. An elastic ball was

then introduced, well up behind the swelling, and distended with five ounces of water. This was borne without pain, and did not interfere with micturition.

After forty-eight hours the ball was removed, when the tumour was found to be entirely above the brim, in fact over-restored, for the fundus could be felt passing forwards well over the pubes, and reaching nearly half way to the umbilicus, whilst the os was high up and pointing directly backwards. A large-sized Hodge (without cross-bars) was then introduced, and its effect has been to keep the fundus in position, whilst the os is falling gradually into its normal position. Patient gets up, feels no pain nor inconvenience, and will shortly leave the hospital. The diagnosis in this case was enlarged retroflected uterus with fibroid in the posterior wall.

Sports.

FOOTBALL.

Last Saturday the Guy's first fifteen paid a visit to Kensal Green, to play a match with the Harlequins.

The ground was nothing but a bed of soft clay, rendering it very difficult to stand, and almost impossible to run, whilst to add to the unpleasantness a dense fog prevailed, which almost obscured the goal-posts. Pinching, who won the toss, elected to play down hill for the first half time. Pugh kicked off for the Harlequins, and before our men could recover their legs the ball was forced over our goal line, and Gibb touched it down, which was decidedly the best thing he could do.

The ball having been dropped out by Gray, a scrimmage was formed, and the forwards set to work, but the slippery state of the ground made their play difficult. Very soon Gray, having got hold of the ball, made a good run, and took the game into the Harlequins' territory, but their forwards playing well together, gradually worked it back near to our goal, until Mutch, having brought the ball through the scrimmage, picked it up, and made the sensational run of the game; making straight for the goal, he passed all the Harlequin backs, and landed the ball between the posts having run three-quarters of the length of the ground. This, considering the nature of the ground, was a very creditable feat. The place-kick was entrusted to Gray, who, with his usual skill, sent the ball over the exact centre of the cross-bar, and scored the first goal for Guy's.

Up to this time Guy's had been playing one man short, but Breach now arrived and made up the full team. The game for the next ten minutes was carried on in our quarters, but just before half-time, Maclean, who was in rare form, made the second run of the match, taking the ball to within ten yards of the goal-posts, but being collared there, he passed the ball to Roper, who ran in and again touched it down between the posts. This was also quickly converted by Gray into a splendid goal. After half-time the Harlequins, playing down hill, had slightly the best of the game, and several times made our backs touch the ball down, but, notwithstanding the excellent runs of Pelham and Pugh, and the good kicking of Watson, they were unable to score anything further, and the match concluded a few minutes before the time was up, owing to the increasing darkness, Guy's having won by two goals to four touch downs.

The following composed the Guy's team:—Forwards—Pinching (captain), Bonsor, H. Duke, Gilbert, Wallis, Keer, Perry, Reader, Mutch, and Wells. Half-backs—Maclean and Roper. Three-quarter-back—Gray. Backs—Breach and Gibb.

In addition to those mentioned above, Pinching, H. Duke, Gilbert, and Wallis played well throughout.

United Hospitals v. Oxford.

This important match came off on Wednesday at Oxford, in a drizzling rain.

Pinching, who was captain, lost the toss, and the ball was started at about 3·30, Oxford having the hill in their favour, and a very easy and fast game ensued, the ball being kept pretty well in neutral ground, until Oxford backing up well, and greatly aided by the dribbling of one of their half-backs, scored a somewhat lucky try, close to the touch line, the kick at goal, however, was unsuccessful. Pearson ran the ball out, and the game was continued with greater spirit than ever, slightly in the Oxonians' favour. At half-time the Medicals getting the hill in front of them got rather the better of the game, the forwards being in capital form, well led by Pinching, and getting the best of every scrimmage, until Jennings, by a beautiful run, nearly got in, being a few feet from the home-team's goal, where a hot maul ensued, and the ball was forced behind, where it was touched down by Oxford. Nothing further occurred, and so the game was left drawn in favour of Oxford. The following represented Guy's:—W. W. Pinching (captain), P. F. Gilbert (forwards), A. W. Pearson (back), W. G. Gray (half-back).

Correspondence.

To the Editors.

Sirs,—A short time ago a copy of your journal was sent to me of the date Oct. 24th, and containing that which soon attracted my attention, an article on the decline of new entries at Guy's Hospital, as compared with St. Bartholomew's Hospital for two successive years, and attributing as the cause that which seems only too manifest, namely, that the superior attractions of two entrance Scholarships, one of £100 and the other of £50, have given the impetus to the entries at St Bartholomew's over those of Guy's Hospital. The article then proceeds to incite the Governors of Guy's—out of such funds as may happen to be at their disposal one may assume—to rally, and assist in supporting the prosperity of her school. I may here inform you that this matter did not pass without attention at the last General Court of the Governors held at Guy's Hospital; after some consideration, it did not appear to the Court that they had at their disposal any funds they could lawfully use in founding scholarships, as had been done at St. Bartholomew's, however they might be disposed to do so. The case at St. Bartholomew's is this: Two benevolent individuals, altogether unconnected with the hospital, by name a Miss Brackenbury and Sir Trevor Lawrence, respectively, left recently by will the sums of £2,000 and £1,000 to its Medical School, to be dealt with for the benefit of such school. After some consideration it was resolved to apply

annually the interest arising from such two sums in the manner as has been so productive of success to the recent entries at St. Bartholomew's. Taking a great interest in all that concerns the prosperity of Guy's Hospital, from long association with eminent members of its former Medical Staff, I should be delighted to hear at any future time that munificent individuals had equally remembered in their wills the Medical School of Guy's in a similar manner to more fortunate St. Bartholomew's. In the meanwhile myself and the rest of the Court of Governors will do the best we can to keep up the pecuniary supplies for the Convalescent Fund of our hospital, which, I think, it will be conceded, can vie in importance and usefulness with that of any other. I would just venture the suggestion, in conclusion, whether, considering the importance of keeping up the new entries at Guy's Hospital to the normal standard, in the interest of the Medical School and Staff, whether, out of the ample funds at their disposal they could not annually put aside, say, the sum of £100 and also of £50, to establish two entrance scholarships as at St. Bartholomew's, and so do something to restore the present waning tide of entries to its former fulness?

I am, Sirs,
Your very obedient Servant,
A GOVERNOR OF GUY'S HOSPITAL.

APPOINTMENTS.

The following gentlemen have been recommended by the Medical Council for appointments :—

OBSTETRIC RESIDENTS—
Messrs. Harsant (Dec), Gibb (Jan.), Morley (Feb.)

DRESSERS—
Messrs. Newman and Lancaster ..... Mr. Birkett
Mr. A. de W. Baker ..... Mr. Forster
Mr. Cock ..... Mr. Bryant
Messrs. Amphlett and Burton ..... Mr. Durham

CLINICAL ASSISTANTS—
Messrs. A. H. Jones, H. Duke, L. Rudd, H. Evans, Morgan, and G. Davis.

ASSISTANT PHYSICIAN'S CLERKS—
Messrs. Creed, F. Bell, Ingram, and Giles.

DRESSERS IN THE EYE WARDS—
Messrs. Ferrier and Tyson (January)
Messrs. Wilding and Bowen (March).

MEDICAL WARD CLERKS—
Messrs. Carrington, H. W. Roberts, Oram, B. Jones, A. S. Lacy, E. Duke, J. W. Bull, Finch, Welchman, A. W. Green, Wilson, Elcum, H. C. Taylor, Mount, Brenchley, and J. Davies.

OBSTETRIC OUT-PATIENT CLERKS—
Messrs. Theed and T. A. Bell.

ASSISTANT-SURGEONS' DRESSERS—
Messrs. Champneys, Jackson, C. J. Symonds, R. Bevan, Brett, W. T. Reynolds, E. B. Mallam, and McCarthy ..... Mr. Howse
Messrs. Kidd, Fell, Routh, Rawlings, Gathergood, T. Duke, J. Mackern, and Chadwick ..... Mr. Davies-Colley.

P. M. CLERKS—
Messrs. S. Smith, H. N. Williams, A. L. Owen, W. M. Evans, and A. C. Brock.

EXTERNS—
Messrs. A. de W. Baker (Dec.), W. Tarrant, T. Jones, H. W. Evans (Jan.), J. C. Wilkinson, J. W. Collington, E. C. Greene (Feb.)

DRESSERS IN THE SURGERY—
Messrs. T. H. Stephens, C. H. Hayes, J. S. Clowes, F. Jones, H. W. Ewen, T. A. Richardson, A. M. Turner, J. T. Grimwood, F. S. Stewart, J. T. Gardner, J. Todd, W. Gibson.

SURGICAL WARD CLERKS—
Messrs. Stevenson, Richards, Gilbert, C. E. Perry, A. Bain, D. D. Roberts, E. C. Beale, R. A. Ross.

ASSISTANT-SURGEONS' CLERKS—
Messrs. Keep (Mr. Howse) and Burt (Mr. Davies-Colley)

AURAL SURGEON'S DRESSER—
Mr. Gibson.

DENTAL SURGEON'S DRESSER—
Messrs. Pedley and T. Jones.

The Wards.

MEDICAL.

The following Cases were admitted between Nov. 18 and Nov. 25 :—

ADDISON.—10—Climacteric. 23—Acute bronchitis. 26—Acute tonsilitis.

MARY—1—Emphysema—death. 1—Chorea. 2—Erysipelas. 10—Phthisis. 30—Polypus. 31—Sub-involution. 37—Ruptured perinæum. 47—Retroflexion—Parametritis. 49—Uterine Hæmorrhage—death. 50—Chronic hypertrophy of cervix.

PHILIP—3—Hæmaturia. 7—Morbus cordis. 15—Acute rheumatism. 21—Acute rheumatism. 22—Subacute rheumatism. 23—Sycosis. 30—Phthisis. 33—Bronchitis. 43—Acute rheumatism. 49—Phthisis. 50—Myelitis.

STEPHEN—10—Acute Bronchitis. 21—Bronchitis. 43—Dyspepsia 41—Phthisis.

BRIGHT—17—Acute tubular nephritis and pneumonia. 20—Acute rheumatism.

MIRIAM—23—Acute rheumatism. 31—Scarlatinal nephritis.

JOHN—6—Paralysis of left arm. 14—Central amaurosis.

SURGICAL.

The following cases were admitted between Nov. 18 and Nov. 25 :—

ACCIDENT.—Closed for repairs.

CORNELIUS.—4—Fractured patella. 6—Scalp wound. 7—Fractured tibia and fibula.

LYDIA.—9—Ulcer of leg. 14—Hæmorrhoids. 17—Enlarged cervical gland.

MARTHA.—1—Chronic synovitis. 2—Acute synovitis. Cot—Abscess of thigh. 20—Webbed fingers 22—Psoriasis of mucous surface of upper lip.

CHARITY.—21—Disease of right knee.

DORCAS.—1—Fractured fibula. 5—Strangulated femoral hernia—operation, 10—Strangulated femoral hernia. 20—Fractured tibia and fibula

LUKE.—11—Dislocation and anchylosis of right elbow.

NAAMAN—1—Disease of os calcis. 3—Necrosis of calcis. 5—General contusions. 6—Fistula in ano. 11—Fractured fibula. 13—Fistula in ano. 13—Extravasation of urine, perineal section. 14—Compound fracture of leg. 16—Necrosis of femur, 21—Amputation of finger.

JOB—1—Old dislocation backwards and outwards of radius and ulna with fracture of humerus. 4—Injury to hip. 19—Necrosis of metatarsal bones. 20—Ulcer of foot. 21—Hydrocele.

LAZARUS.—1—Varicocele. 8—Onychia syphilitica. 13—Recto-vesica fistula. 18—Crushed hand.

ASTLEY COOPER—3—Swelling in perinæum. 13—Epithelioma of tongue. 16—Phlebitis, 23—Pott's fracture. 23—Fractured clavicle and ribs.

ERRATA.—In Dr. J. Braxton Hicks' Lectures, last week, in page 58, second column. tenth line rom bottom "descends" for "ascends." Page 59, first column, third line, omit "till,'' and sixth line, "relaxation" for "reaction," and twentieth line, "till" for at "last," twenty-fourth line, omit from "until at last" to "interval." thirteenth line from bottom, omit "as in dilatation"

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Guy's Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 10. SATURDAY, DECEMBER 5, 1874. TWOPENCE

THERE is not, we believe, in London, a Hospital where the Students' appointments are so numerous and valuable as at Guy's. What a pity it is, then, when there are such good opportunities offered for gaining practical knowledge, that men will not make the most of them. We by no means say that some do not try to gain all the experience they can at Guy's, by holding as many appointments as possible, but, speaking of the very large majority of men we know well their aim is to hold only just sufficient appointments to obtain the requisite certificates. To do this, it is necessary first to be "Surgical Ward-clerk," without which they cannot gain the other appointments. They must then be signed up for six months engaged in dressing. How is this to be done? Most easily, by taking "Dresser in the Surgery" and "Assistant Surgeon's Dresser." These appointments give men, we allow, much practice in minor surgery, such as dressing slight cases, amputating fingers, tapping hydroceles, and putting up fractures of the upper extremities and ribs, but can never fit a man as the dressership does, for attendance on those more severe cases which are taken into the wards, and notably for putting a fractured leg in splints. Another requirement of the College is three months' Clinical clerkship, and this is accomplished by taking "Medical Ward Clerk," a splendid appointment, but far inferior to that of "Clinical Assistant," when the student has the pick of all the cases which come to the hospital. "Assistant Physician's Clerk" is generally looked on as almost useless, as it occupies but one day in the week, and the diligent man often thinks there is little to be learnt in giving out cards to twenty cases, and then writing for the Assistant Physician. This is probably the reason why only four men applied for the appointment last week. We believe that for practising diagnosis this is one of the best opportunities offered at Guy's. Let a man go to the out-patient-room at 10 a.m. and spend three hours in selecting cases for the Assistant Physician, and for the Junior House-Physician, and let him, after a careful examination of each patient, write down on paper the physical signs of disease he has discovered with his diagnosis, and be convinced of his errors by the Physician, and, we believe, such a man after the three months will have gained an immense knowledge of the diagnosis of diseases. Of "Extern," we will only say it is a necessary evil, but of itself insufficient to give a man confidence for general practice. Often an Extern attends fifty confinements without seeing an abnormal case; and this should be a stimulus to men to strive for the "Resident Obstetric," when they not only see all the abnormal cases, but get at least a slight knowledge of gynæcology. Of the ophthalmic, aural, and dental departments, all will confess the value of a knowledge, but these are special subjects which a man should learn if possible, but which may be more fitly omitted than those before-mentioned.

A STUDENT'S NOTES OF

Lectures on Midwifery.

—o—

By J. BRAXTON HICKS, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

LECTURE VI.

POSITION OF DELIVERY.—Doubtless throughout the whole

of labour it is of much importance to bring the axis of the uterus in coincidence with that of the brim of the pelvis, or otherwise a loss of power ensues, with some detention of labour, in consequence of the pressure of the fœtal head against the brim or side of the pelvis.

The best plan, particularly in the early stages of labour, is to place the patient on her back; by this means the axes are made nearly coincident, but also the line of gravitation is made more or less in accordance with the axis. But in English practice the patient is almost always placed on her left side, and thus the upper portion of the uterus hangs down to the left side, at a lower level than the brim: thus not only counteracting gravitation, but also making the line of uterine force in non-accord with the line of exit. This is somewhat corrected by placing a pillow beneath the dependent side till the axes of brim and uterus are coincident; otherwise it is just possible, besides the lengthening of labour that a mal-presentation may result, especially if the lower pole of the fœtus be already at the beginning of labour somewhat inclining to the right side, and thus may be produced a hand with head, shoulder, or even transverse presentation. Besides the pillow, a bandage round the abdomen tends to rectify the error, or a small pillow may be enclosed within it and placed on the left side of the uterus.

It is customary to have a towel to pull at, attached to the bed-post next the patient's feet. This is useful in fixing the thoracic muscles, and thus enabling the auxiliary forces to assist better. With multipara it generally answers well, but in primapara, who frequently extend themselves during a pain, it is often best to put the towel aside, and to give her hand to some one to hold, or, in the last stages, to make her place her hands over her knees and pull at them. At the last moment she should be instructed not to bear down, and to relax all hold, to breathe freely; this frequently saves the excessive force which might rupture the perinæum.

When the head is fairly bulging out the perinæum, the time has come to "support the perinæum," as it is called. The old-fashioned method of pressing back the child's head through the perinæum as soon as its bulging could be felt, has been discarded; our object is to save this part from rupture. This we do by being at hand to prevent a sudden escape of the head by violent pains, and to relax it as much as possible. If, when the head is protruding through the vulva, we place our fingers on it, just at the margin of the perinæum, we can always feel the signs of, and almost prevent the sudden escape of, the head. By pressing the head back through the perinæum we can check its movement, and direct forward beneath the arch of the pubes. Pressure on the head effects retardation, and pressure on the posterior portion of the perinæum will direct the head forwards. To relax the perinæum, the thighs should not be bent too highly on the pelvis, about midway between flexion and extension. If the patient be delivered on her back, the same rule should be observed. There is one case when it is advisable to retard the advance of the head, viz., when the uterine action is feeble, and the advance of the head rapid, in such case the uterus is not sufficiently roused for the reflex irritation to be persistent, and retention of placenta is liable the ensue after delivery.

To reflex the perinæum we should also employ warm fomentations, and for this end the diaper, in common use to protect our hand from fœcal soiling, answers very well. It may also be well anointed, and a large piece of lard passed inside vulva to assist friction; a warm water enema assists also in relaxing the parts, and, in severe cases of tight perinæum, inhalation of chloroform gives great help in the same direction. I have found often that during the interval of a pain the perinæum is less tight, and that if the head is on the point of delivery, and there is fear of rupture, this may be avoided by gently drawing the head out, assisted by pushing externally the head forward.

As soon as the child is born, the mouth should be cleared out of the secretions which may have entered it; and it is well, if there be any difficulty in the breathing, to place the child face downwards, to allow the fluids to escape. It should then be noticed whether the funis is twisted round the neck, and if so it should be uncoiled. This should be done so as not to draw too tightly on the umbilicus. If the funis be so short that it is impossible for the greater part of the body to be born, then the funis should be divided, even if within the vagina, and, without tying, taking care that the fœtal end be held till it can be properly tied. It is not necessary to tie the placental end.

But if the funis be natural, it is best to allow the respiration of the child to be well established before the funis is divided. When this has taken place, then ligature should be placed round it. First, about four inches from the umbilicus, and, second, about three inches from that. Between these the funis is to be divided. It is well to compress the blood between before the second tie, or you may be bespattered.

Sometimes, when the child's breathing is languid, I compress, for a moment, the cord; this generally causes inspiration, and this can be repeated as required. As soon as, if not before, the child's head is born, an attendant is instructed to place her hand on the uterus outside, and to gently press down; this generally insures the expulsion of the fœtus, but the child in ordinary cases is not be dragged forth immediately, the presence of the child in the passages keeps up reflex action and ensures the continuation of the uterine contraction. When the child is born examine it, to see that it is properly formed, and, as soon as separated, place it in the "receiver," and hand it to the nurse, or place it in a safe and warm place.

Now direct your attention to the uterus, place your hand on the abdomen, and make out the size and form of the uterus. If it be larger than the fœtal head, there is probably another fœtus within. Examine over vagina carefully to ascertain this point. If a fibroid tumour be in the walls a difficulty may arise, but careful examination will enable you to make your diagnosis. If the placenta be partially peeled off the uterus, while the membranes round the cervix are detached, a collection of blood takes place, distending the uterus, and bulging down the membranes from above, and thus you may suspect a second fœtus, but if this new bag of membranes be ruptured, nothing but blood escapes, and your mistake is revealed. Although I have seen two or three such cases they are by no means common.

Immediately, then, the child is detached, if you have not done so before, place your hand on the uterus from the outside and note its condition. If there be no child there it will be found in one of four conditions:—

1. Large and firm.
2. Large and soft.
3. Small and hard.
4. Alternately hard and soft.

In the first kind the placenta is still within the uterus, which is in a state of contraction; in the second, the placenta is within the uterus, which is not contracting,

more or less relaxed. In the third the placenta has escaped the uterus, which is firmly contracted. It is about the size of a cricket ball, while in the first state it is about the size of a fœtal head. In the fourth state we may find the placenta expelled or not, but the condition is one of intermittent action. To a certain extent this is a natural condition, for the uterus almost always acts intermittently, but at this period the condition may be attended by hæmorrhage, if the placenta should be detached ever so slightly, when the relaxation takes place, and this is made evident when the uterus contracts, a free gush of blood then taking place.

There is no safety in any condition except the third, namely the empty and firmly-contracted uterus. Of course I cannot even here say there is absolute safety even with this state, but I speak in relation to the other conditions.

As long as any placenta, however slightly detached, clot, or other body remain in the uterus, there is great liability to hæmorrhage or "flooding." If the uterus be firmly contracted upon the placenta or clot there is but little bleeding, although it may be freely separated; but as soon as relaxation occurs bleeding instantly begins. If the placenta be entirely adherent, then, although it may be completely relaxed, there will be no flooding; but this is rarely the case. Therefore, as long as the placenta remain there is danger of hæmorrhage.

Report of a Case.

L. D., æt. 52, was admitted into No. 7, Bright Ward, under the care of Dr. Moxon, Oct. 16, 1874.

Family History, good; no history of cancer or phthisis.

Patient is a domestic servant, unmarried, and has never been robust; has had the ordinary complaints of children.

Present illness commenced a year ago, with loss of appetite followed by uneasiness after food, sickness, and prostration Nine months ago she first had pain four hours after food (especially after hot articles of diet, such as tea, &c.), with tenderness on pressure, flatulence, eructation and deranged appetite. There has not been any melæna, but at times her motions have been very pale, and the bowels relaxed. Hæmatemesis has not been marked, but two days before admission she brought up something which was described as coffee-grounds.

On admission, patient is somewhat emaciated, and of a slightly anæmic aspect. Tongue furred and dry, fissured longitudinally and transversely. Bowels constipated. Abdomen is distended with flatus, stomach resonance extends as high as the lower border of sixth rib, but is lost below in abdominal resonance caused by flatus. Recti muscles are tense, no tumour can be felt in abdomen, there is slight pain on pressure over the stomach, more severe at pyloric end. No pain on pressure down the back, or on either side of the spine.

Liver and spleen apparently normal.

Chest fairly well formed, with prominence at upper part of sternum. Lungs appear to be healthy, breath-sounds natural but feeble. Heart's action normal.

Urine acid, dark-coloured, contains blood-cells, and is slightly albuminous. Sp. gr. 1024.

Pulse 100, temp. normal.

Oct. 18th. Patient seems much easier; bowels open; slept well.

Oct. 19th. Complains of severe pain in her abdomen; vomited this morning.

Oct. 20th. Dr. Moxon examined the patient; the abdomen was very tense, and the peristalic action of the bowels well marked. This, says Dr. Moxon, shows probably some obstruction of the colon, but as trouble seemed all gastric, not much notice was taken of this. Patient came in with diagnosis of ulcer of the stomach, all pain being in this region. Constipation was never a prominent symptom.

Oct. 21st. Bowels open once to day, vomited again yesterday.

Oct. 22nd. Vomited very much last evening, and brought up a quantity of dark coloured fluid containing blood. Woke up between two and three in the morning with great pain in the abdomen, which continued to get worse, with constant vomiting until 10·45 a.m., when she died.

P.M. Intestines presented a dark purple appearance, the cœcum being enormously distended and filled with a yellowish fluid. A malignant growth was found involving the hepatic flexure of colon, constricting the passage so that the finger could scarcely be passed through. The mucous membrane had ulcerated, but there was no perforation. Stomach healthy, but adherent to growth. Bowel above stricture filled with yellow stuff, below a few pieces of dry fœtal matter. Supra renal capsules and liver had nodules of cancer. There was a small villous growth on the mucous membrane of the bladder, which accounted for hæmaturia. Lungs normal. Heart dark brown and atrophied.

It is not very unusual for the stomach and colon to be involved in the same malignant disease. Dr. Moxon has twice seen these parts affected with cancer in the same subject, although the cancers of colon, in the one case sigmoid, in the other upper rectum, were away from all direct connection with the stomach. Sometimes a cancer of the colon will involve or even open the stomach, or a cancer of the stomach will reach and open the colon, the latter more frequently. Such an occurrence would be no doubt oftener met with, if it were not that cancers are comparatively very rare in the transverse part of the colon, which is neighbour to the stomach. The case of L. D. shows that an unnatural drag upon the stomach by its attachment to a diseased part may give to the case the character of gastric disease through predominance of the gastric symptoms. It also shows what has been often demonstrated of late, that visible intestinal pristalsis should lead to a strong belief that there is organic obstruction of the intestines in the case. It is to be observed that in this case the bowels were relieved daily after admission, notwithstanding the cancerous obstruction revealed at the post-mortem examination.

Correspondence.

To the Editors.

Sirs,—In your *Gazette* for September 5th, which I have only recently had an opportunity of seeing, I observed an article entitled, "Notes on the Aberdeen Medical School," which is both annoying and disgusting, inasmuch as it is another display of those petty animosities which exist among the smaller minds of large schools.

The article referred to contains much that is positively false, and a great deal of misrepresentation. I cannot see any reason that could prompt your correspondent to endea-

vour to circulate false reports about the University of which he ought to be proud that he has been able to become a graduate: and I feel greatly surprised that such a course should have been taken by a member of the medical profession.

The author of the "Notes" asserts that only *one* course of Surgery is attended by students of this University. Now, this is untrue; I know of no student in my own year, who has not attended *two* courses of Professor Pirrie's most valuable lectures, or rather demonstrations, on Surgery.

Again, he says, "all *read* their lectures;" now, I defy him or anyone else to prove that he has ever heard a *read* lecture on Anatomy. Surgery, Chemistry, or Botany—essentially demonstrative subjects—in this University. I have heard men from the best London schools confess that on these four subjects the Aberdeen teaching is not to be surpassed. The lectures on Medicine, and such subjects, I confess, are read, and, I think, preferably so.

Not within the memory of the present generation has bleeding been recommended in phthisis, as your correspondent would have us believe.

He praises highly our museums of Natural History; well, it certainly is a magnificent collection; but it is to only a small fraction of it that the medical student can devote much attention. The rest of our museums he depreciates on account of their comparatively small size. The fact is, he is labouring under the delusion that enormous halls, full of professional curiosities, are needful for a medical student's education. Nothing could be more misleading. If the curriculum extended over ten years instead of four, then might the student amuse himself with such institutions. Even if our museums contained no more specimens than are needful to illustrate the professor's lectures, I should be contented, for that would be even more than one could study thoroughly. Almost every professor here has his own separate museum. Thus the specimens are distributed over a large space, and, consequently, do not show to the best advantage. In one of the largest London schools, the student is pestered with the sight of butterflies and creeping things amongst the objects for anatomical study; here separate rooms are provided for each. Perhaps the London arrangement is done for the sake of variety.

That the pathology taught at Aberdeen is behind the age I deny emphatically.

The insinuation that the assessor examiners do not ask questions is likewise untrue.

Had the author of the "Notes" not been one of those students who "wander listlessly round the wards," he could not have found much fault with the clinical teaching.

The female lock ward is open daily, and free to all students.

If it is true that our critic was eagerly asked if he had ever seen an os uteri, on an occasion of one being exposed, the queries must have been put by first-year's men, who mistook him for one of their own class.

Only the other day, a student informed me that he had learnt more from one month's attendance on Professor McRobins's lectures on Medicine, than in the whole of two courses he attended at one of the largest London schools. In London, he says, such terms as bronchophony, sibilus, œgophony, &c., were used often enough, but never explained to the students.

A M.R.C.S., whilst commenting on the value of the prescriptions given in lectures here, informed the writer that he had frequently been able to diagnose disease, but was at a loss what to prescribe; in other words, he could tell what was wrong, but how to put it right was a different thing—he had been half educated.

I am pleased to see that our critic has given such high praise to our excellent Professor of Anatomy; it contrasts somewhat strongly with the unscrupulous denunciations indulged in, in other parts of this paper.

When your correspondent attacks the pronunciation in this part, he is upon dangerous ground. My ears are uncivilised enough not to perceive that even broad Scotch is much inferior to the abominable English one hears in London. Here, the letter *h* has a place in the speaking as well as in writing; *idea* never developes into "idear," *dog* into "dorg," *row* into "wow"; *put* is not pronounced so as to rhyme with *but;* all of which, and many more similar murderings of English, one continually hears from London gentlemen who come down here, expecting to astonish the natives.

My own impression of London schools is not very favourable. I was much struck with the inattention, want of deference to teachers, and noisiness, of the students. When a lecture was a little more than half over, one by one the students shuffled towards the top seats, and sneaked out. A certificate of attendance on lectures in many of the London schools, shows little more than that the owner has paid his fee.

If our metropolitan friends possess that practical knowledge which they are so ceaselessly vaunting, why don't they outstrip us in the competitive examinations? Surely practical knowledge can hold its own against any amount of book-work. When one knows a subject practically, how easily and confidently one can write about it, compared with having an acquaintance with it only through books. But, sir, I am afraid it is more a difference in the amount, than in the kind of knowledge.

The high position which Aberdeen men take in the public service examinations, and the great scientific eminence to which so many of our graduates have attained, are sufficient proofs that the teaching in this University is of the very highest quality.

In the Army competitive examinations, more *firsts*, and more high places, have been taken by Aberdeen men, than by students from any other medical school in the world.

Our critic must surely have dreamed a dream, and given us what he recollected of it in the shape of the "Notes." If so, it would have been better to have made a foot-note to that effect. He reminds one of the eminent physicians of old, who used to sit down and detail the symptoms of diseases as their own fertile imaginations dictated.

In conclusion, allow me to apologise for troubling you with this reply, which, though it be an irregular proceeding, I hope you will feel in justice bound to admit into your valuable columns.

I am, Sir,
Your obedient servant,
An Englishman at Aberdeen University.

To the Editor.

Sir,—There is one little want at Guy's, which I am sure the school authorities only require to have brought to their notice, and we shall have it supplied, and that is the need of a good set of bones in the Anatomical Theatre.

It must be apparent to all how much easier it is to learn, and remember the exact attachments of muscles, if whilst reading and dissecting them, and especially in the former

case, one can constantly refer to those attachments on the bones themselves, and that this is known to be the case, by our Demonstrator is shown by the increase in number of bones in the Dissecting-room this winter. An articulated skeleton suspended at one end the Museum would be of great assistance in studying the relations of parts to one another, and I don't think any one would walk off with *that*.

Yours, &c.,

BONES.

Obstetrics.

A. B., in her eighth confinement, had felt no fœtal movement for six weeks, when she hurt herself carrying a weight. The whole of this time she has felt a cold heavy weight at the bottom of the stomach, and the breasts have become dry, the milk having run away shortly after the injury. She was barely six months gone when labour came on, and the hand was found to present. Dr. Galabin was communicated with, and on his arrival the right hand was outside the vulva, and the right front of the chest presented at the brim. Patient was placed under chloroform, and Dr. Galabin himself introduced his left hand, but the os was so small as scarcely to admit it. The finger could just reach over the groin, which was depressed, until a foot was felt, which was seized and brought down. It proved to be the right. The left followed, and within a minute a wasted, but not decomposed, child was delivered. The placenta soon followed. The vagina has been daily washed out with permanganate lotion, and the patient is doing well.

E. N., æt. 19, was confined (about three a.m. on the 23rd inst.), the labour being over before the arrival of the extern. She had had a fit, but was comfortable with a pulse of 60 when the extern left. During the day she had several more fits, and at 5·20 the extern found her unconscious and breathing with difficulty; pulse 130. At 7 p.m., the junior went down to the case. Patient was then comatose. Both pupils were contracted, the conjunctiva quite insensitive; skin was moist, and the surface a good deal congested; the abdomen was distended and drummy. She had passed no urine since delivery, a catheter was used, and a small quantity of water drawn off. This was high-coloured and loaded with albumen; on microscopic examination it was found to contain a large number of granular casts. Temp. 107, resp. 35, pulse 130, scarcely perceptible. The surface was sponged with water at 95°. The surface temperature sank to 104 F., but the vaginal temperature was 108·8 F. after the sponging. Patient was able to swallow brandy and water, which was given in small quantities every five minutes. She never rallied at all, but died before the arrival of Dr. Galabin and the senior at about 9·30 p.m.

DIPSOMANIA.—Contrary to the usual opinion, which attributes to the inhabitants of the British Isles the greatest average of drunkenness, the *Ausland* states that this vice flourishes to the greatest extent in the United States and in Russia. The asylum provided by the State of New York to receive confirmed drunkards contains 800 inmates, who are classified as follows:—30 clergymen, 18 judges, 197 lawyers, 226 medical men, and 340 unclassfied, but chiefly consisting of merchants, artisans, and business men.—*London Medical Record.*

FOUNDERING OF THE "LA PLATA."

WITH the arrival of the *Antenor* steamship, on Wednesday last, came the fearful news of the loss of the *La Plata* and sixty lives. The *La Plata* sailed from Gravesend on Thursday, Nov. 26th, for Rio Grande de Janeiro, to lay a new Submarine Cable, and on board she carried as surgeon a gentleman who will be known to the greater number of those who have been at Guy's within the last ten years, Dr. J. Rigby-Hughes. When in the Bay of Biscay, the ship was overtaken by a terrific gale, and, after being swept over by some tremendous seas, at last sprang a leak, and foundered off Ushant, carrying with her some sixty souls, and among them, we regret to say, our late fellow-student. Dr. Hughes. Fearful as seems such a death, we are proud to learn that Dr. Hughes acquitted himself with coolness and valour, he and the captain being the two last seen standing on the bridge when the ship went down. Fifteen only of the crew were saved in a boat and picked up by the *Gare Loch*, whence they were transferred to the *Antenor*.

THE HEALTH OF LONDON.

THE sudden fall of temperature last week raised the mortality in London to 30 per 1,000 per annum. This is about 8 per 1,000 higher than the average death-rate in the metropolis. The number of deaths from epidemic diseases slightly declined, whilst bronchitis, pneumonia, and phthisis served to swell the list.

THE PHYSICAL SOCIETY.

THE fifth meeting of this Society will be held this evening, at 7·30 p.m., in the Chemical Theatre, when Mr. Branfoot will be in the chair, and Mr. McCarthy will read a paper upon "The Physiological effects of Chloroform."

MARRIAGE.

ON the 23rd ult., at St. George's, Bickley, Stephen Wootton Bushell, B. Sc., M.D. Lond., Physician to H.B.M. Legation, Peking, to Florence Jane, eldest daughter of Robert Mathews, Bickley, Kent.

A NEW BOOK ON DENTISTRY.

A NEW book on "Dental Surgery and Pathology," by James A. Salter, M.B., F.R.S., Dental Surgeon to this hospital, has just been issued by Longmans & Co.

Operations.

Nov. 23.

Mr. Davies-Colley operated on a patient for crushed legs, the result of a railway accident. The right thigh was much crushed and the left foot torn off, leaving several inches of tibia totally denuded of flesh. There was severe collapse with jactation on admission, and it was doubtful whether an operation was advisable. After the application of warmth and administration of stimulants, the patient revived and it was resolved to give him the only chance which afforded a prospect of life. The right leg was amputated near the hip, and the left through the knee-joint. Chloroform was given at the commencement of the operation, and this was followed by ether; the collapse of the patient, however, became so severe that this was discontinued. The patient did not long survive the operation.

Mr. Durham commenced to trephine a patient who had just been admitted into Naaman for fractured skull. The man was evidently dying with compression of the brain, and with hopes of relieving this, which was probably caused by hæmorrhage, the trephine was placed over the middle meningeal artery. Before, however, the bone could be raised, the patient ceased to breathe. As there appeared to be some obstruction about the larynx, the House-surgeon, at the request of Mr. Durham, performed tracheotomy, and the patient was kept alive by artificial respiration for some time. No anæsthetic was used.

Nov. 24.

Mr. Bryant put a man on the table for lithotomy, but as the stone could not be felt *at the time* by the sound, the cutting operation was refused. The stone had been felt in the ward previously by the House-surgeon and dresser, but not by Mr. Bryant. Mr. Bryant remarked on the great value of the rule which is in force at Guy's—that no patient is cut for stone unless the stone is felt just previous to the operation, and narrated instances in which the observance of this rule had been the cause of preventing deaths being attributed to lithotomy which otherwise might have been.

Mr. Bryant removed a piece of dead bone from the femur of a man; a considerable quantity of new bone had to be cut away before an aperture could be made large enough for extraction of the necrosed portion. One piece was very large, and consisted in some parts of nearly the whole thickness of the shaft of the femur.

Mr. Davies-Colley operated for the removal of a thyroid cyst, but owing to the extensive connections of the base and the thinness of the walls of the cyst the tumour was merely opened and allowed to suppurate.

Nov. 27.

Mr. Bryant removed an epitheliomatous tongue with the galvanic cautery by a new method. A large semi-circular pin was introduced behind the symphisis of the lower jaw, and brought out in the mouth at the back of the tongue at the junction of middle and posterior thirds, and left in position with the point projecting above the dorsum of the tongue. A needle in handle, armed with a twisted platinum wire, was then passed through the same opening, but made to appear in the mouth in front of the frenum linguæ. The needle was then withdrawn, and the loop passed over the tongue and the end of the pin just introduced. The ends of the wire were now attached to the cautery and withdrawn, and necessarily kept behind the curved pin. In this way it will be seen that the tongue and the muscles attaching it to the jaw and hyoid bone were completely divided.

Mr. Bryant reduced an old dislocation of the radius and ulna. The bones were displaced backwards and outwards, there had been also some fracture of the humerus which complicated matters. The bones were with some difficulty reduced and kept in position. The arm was put up on an anterior right-angled splint.

Nov. 29.

Late in the evening Mr. Howse operated for strangulated femoral hernia, in Martha Ward. The constriction was very tight, and with difficulty divided. The period of strangulation was doubtful.

Nov 30.

Mr. Howse operated in Martha Ward for strangulated hernia. The bowel had been down for twenty-four hours. It looked healthy, and was returned without much difficulty.

Dec. 1

Mr. Birkett removed some recurrent nodules of carcinoma from the breast of a woman on whom he had previously operated. The cicatrix was excised as well as the cancer. The flaps came together very well. Mr. Birkett remarked that the corpulence of the patient was against her recovery, union of such wounds in thin people being much more rapid.

Mr. Birkett removed an epithelioma of the tongue. Pins were passed behind the tumour and the wire of the cautery encircled the tongue behind these. There was a little bleeding after the operation, which was controlled by the cauterisation and pressure.

Mr. Bryant performed lithotomy on a patient who had been placed on the table a few days previously, but was taken away because a stone could not then be felt. Mr. Bryant said it was his intention to cut the man whether he found a stone or not, for his bladder was in that state which would be greatly benefitted by a free incision. When pus collects in other parts of the body we let it out by incision, and when the bladder gets into the useless state in which this man's had, the treatment should be the same. The lateral operation was performed, and a pliable phosphatic stone extracted.

Sports.

FOOTBALL.

Guy's v. London Hospital.

This match was played on the ground of the latter at Victoria Park, last Saturday, under some difficulty, owing to the unruly behaviour of the spectators, who would persist in crowding on to the ground, several times materially obstructing the movements of the players.

The London captain started the ball at 3·15, and, notwithstanding the fact that Guy's had only seven men forward, they managed to keep the ball close to the enemy's goal for some time, and nearly always got the better of the scrimmages. At length Pearson got the ball, and by a good run, took it well down to the other end of the ground. Soon after this, one of the London men made his mark, and by a good drop sent the ball behind the Guy's goal-line, where it was touched down in self-defence. The play was now pretty even, until Shapley, by a good run, succeeded in getting in with the ball, but, making a mull in bring it out, he lost the try.

After half-time Guy's had the best of it, and during the last quarter of an hour the ball was kept close to the London goal. Nothing, however, was scored until two minutes before "no side" was called, when, by a rush, the ball was taken behind, and touched down by Wallis. Gray kicked the goal, thus winning the match for Guy's by one goal, to one try and one touch-down. Guy's played throughout the match with only twelve men.

The following formed the Guy's team:—Forwards—Pinching (captain), Gilbert, H. Duke, Hetley, Mutch, Perry, and A. Carey. Half-backs—Roper and Welchman. Three-quarter-back—Gray. Backs—Wallis and Keer.

FOREIGN BODIES IN THE DIGESTIVE CANAL.

The incident of the *homme a la fourchette*, the man who swallowed a fork in Paris in April last, has inspired M. Mignon with the idea of collecting all records of similar cases. He has been able to find details of one hundred and sixty-three, and it would be difficult to imagine anything more astonishing than the catalogue (given in the *Union Medicale* for November 3) of the objects swallowed by either veritable lunatics, or what may be termed sane idiots. Amongst the very indigestible and uncomfortable items catalogued we find fifteen gold medals, hair rings innumerable, 175 francs, a shoe buckle, nine inches of a sword blade, very sharp scissors, eighty pins, a baby's bottle, the castor of a night-stool, an entire set of dominoes (the size of which however is not stated), one hundred Louis d'or, a flute four inches long, a glass phial, thirty-five knives, a clay pipe, from fourteen to fifteen hundred pins, a bar of lead weighing a pound, a whetstone, and (in three instances) a table fork. But the most extraordinary of all these cases occurred in the instance of a convict who died at Brest in 1773, and on whose body a necropsy was performed. The stomach was completely displaced and occupied the left hypochondrium, the lumbar and iliac regions of the one side extending into the pelvis nearly as far as the foramen ovale; it contained fifty-two different objects, weighing altogether 1 lb. 10 oz. Amongst them was a part of the hoop of a barrel, nineteen inches long and one wide. M. Mignon has classified these 163 cases into three categories. 1. Foreign bodies which passed through the whole extent of the digestive canal with scarcely any injurious results. 2. Foreign bodies which passed through the whole extent of the digestive track, with more or less serious results, but ultimate recovery. 3. Foreign bodies, which have passed through the whole digestive track, causing serious disturbance and fatal results. 4. Cases in which the foreign body has not been passed. 5. Cases in which operations have been performed. It is a remarkable fact that the cases of death caused by the presence of foreign bodies in the digestive tubes are less numerous than might be expected Out of the 163 cases, we only find ten deaths from this cause. To these must be added two deaths after operation, making altogether twelve, or 7·3 per cent. There appears, therefore, to be no great cause for the surgeon to be over anxious in these cases, but to remember that unless there should either be some complications in the general health or some special indication, it will be as well for him not to interfere, and above all things not to perform gastrotomy, save as a last resource. Of this last operation M. Mignon relates five cases; amongst them being those which Mr. Neal, in 1855, and Mr. Bell, in 1859, thought themselves obliged to perform, the one in order to extract a bar of lead ten inches long, and weighing a pound, the other to do the same with a bar of lead, nearly twelve inches long, and weighing more than nine ounces. In both these cases the symptoms were very serious, comprising violent pains in the stomach, twitchings along the vertebral column, sickness and general prostration. The foreign bodies could not be felt through the abdominal walls, but the surgeons decided on performing the operation, thinking that the sufferers had no chance of relief by expulsion *per anum*. The success of the operations was fortunately complete.—*London Medical Record.*

Tottenham Court Road Chapel.—The Rev. L. D. Bevan, LL.B., will deliver a lecture on Sunday evening, December 6, subject: "To Medical Students. The Art of Healing." This is one of a course of lectures to Students. Seats are provided for strangers, and service commences at half-past six.

The Wards.

—o—

MEDICAL.

The following Cases were admitted between Nov. 25 and Dec. 2:—

Mary—4—Febricula, 15—Bronchitis. 16—Menorrhagia anæmia. 17—Chorea. 20—Subacute rheumatism. 22—Acute bronchitis. 32—Polypus. 33—Ovarian tumour—ascites. 34—Ovarian dropsy. 37—Ruptured perinæum. 44—Dysmenorrhœa. 45—Subinvolution. 50—Fibroid in anterior wall of uterus. 52—Bronchitis.

Addison—11—Albuminuria. 16—Osteo arthritis. 26—Albuminuria, cirrhosis. 34—Phthisis. 35—Hysteria.

John—6—Pneumonia.

Bright—6—Diabetes. 10—Rheumatism. 13—Morbis cordis and syphilis.

Philip—7—Pyrexia. 27—Leucocythœmia. 38—Bronchitis and albuminuria. 48—Pleuro-pneumonia.

Stephen—3—Chronic rheumatism. 7—Acute pleuro-pneumonia. 18—Mitral regurgitation. 20—Facial erysipelas 22—Phthisis. 26—Aortic disease. 28—Cirrhosis. 31—Chronic phthisis. 32—Chronic rheumatism. 34—Sycosis. 38—Paraplegia.

SURGICAL.

The following cases were admitted between Nov. 25 and Dec. 2:—

Cornelius.—5—Crushed arm—amputation.

Lydia.—4—Ulcers of leg. 12—Malignant disease of rectum. 15—Syphilis—perimetritis.

Martha.—6—Suppurative inflammation of hand. 7—Fractured tibia and fibula. 8—Recurrent carcinoma of breast. 15—Strangulated femoral hernia. 16—Strangulated femoral hernia. 20—Fractured thigh. 21—Lobular hypertrophy of breast.

Charity—2—Syphilis. 5—Traumatic arthritis. 6—Disease of hip. 7—Syphilis.—11—Hæmorrhage from fissured nipple.

Dorcas.—1—Loss of power and sensation in thumb. 12—Eczema. 18—Thyroid cyst.

Luke.—3—Strumous ulceration about hip. 5—Embolism of abdominal aorta. 10—Calculus. 14—Strictnre. 18—Hæmorrhoids. 19—Irredupible hernia.

Naaman.—No admissions.

Lazarus.—5—Concussion. 10—Synovitis. 12—Synovitis. 14—Bruise of hip. 15—Crushed fingers. 19—Inflammation about knee. 20—Wound about knee. 22—Injury to leg.

Job.—13—Eczema. 14—Disease of bones about ankle. 21—Hydrocele.

Astley Cooper.—1—Talipes varus. 11—Phlebitis of orbit. 17—Disease of elbow. 22—Fractured ribs.

Accident.—Closed for repairs.

Deserts as Health-Resorts.—At a recent meeting of the Munich Academy of Science, Professor Eittel read a paper, detailing the results and observations made by him with regard to the air of the Lybian desert during the months of January, February, March and April, 1874, tending to prove that this desert contains a very much larger amount of ozone than that of the oases, or the Nile valley. The belief that the desert air is beneficial to invalids, especially those suffering from pulmonary complaints, is of ancient origin, and, in accordance with this idea, the Khan has recently decided to repair to Helnau, in the so-called Eastern, or Arablan, desert of Egypt.—*London Medical Record.*

ANSWERS TO CORRESPONDENTS.

We have a received a letter from "Lucus a non Lucindo," complaining of a deficiency of gas in the Out-patient Rooms. We understand that this subject is at present receiving the attention of the Hospital authorities.

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Guy's

Hospital Gazette.

DARE QUAM ACCIPERE

A Student's Journal of Hospital News, Medicine, & Surgery.

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IN the midst of hard work, and with certain duties to perform, it is easy to indulge in one form of procrastination without giving a thought to its consequences, and with the hope of one day having more time for studying in any particular department, a student may allow useful opportunities of turning his attention in that direction pass by unimproved. At its longest a man's term at the Hospital is but short, and should he desire to make the most of it he would do well to adopt some system of working which will give him a practical insight into the various departments at the Hospital. We are not backward in finding out the defects of everything around us, but might be much quicker in securing the grand advantages offered to us as students of a large institution.

We have lately remarked on the importance of a few of the branches of our study which have been somewhat neglected, and we would suggest that that neglect is often the result rather of procrastination than of intention. For by leaving any one branch while another is being attended to, in the hope that a future time may be more fitting for its study, that branch is often neglected for want of the hoped-for opportunity. It would be too much, of course, to expect that any man should pass his curriculum without any regret as to lost opportunities or misdirected effort; but there is often more regret in the end than there would be, if, at the commencement, there were due consideration given to the work to be accomplished.

We accordingly hope that after the festivities of this season have been brought to an end—and we trust that every Guy's student may spend a very merry Christmas—we may each endeavour to make the most of the advantages here offered to us. The out-patient department, the post-mortem room, and the operating theatre will yet afford room for more than are in the habit of attending them, while a visit with the Physician or Surgeon for the week will give many lessons that will prove useful in after life; and a man who has prepared himself for his future career need never fear the examinations which stand as the portals to that career.

We therefore recommend to any student who is postponing any special work to a future opportunity to consider fairly whether he has not that opportunity *now*, or if he cannot conveniently *make it now*, and by a systematic arrangement of his time at Guy's, allow due attention to each of the departments we have named; not, however, to the exclusion of the more special ones for the eye, ear and obstetric, and skin diseases.

A STUDENT'S NOTES OF

Lectures on Midwifery.

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By J. BRAXTON HICKS, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

LECTURE VIII.

HOW TO REMOVE THE PLACENTA.—1. By Expression.—The grasping of the uterus by the hand, as already mentioned, in part assists in expelling the placenta; but if this fail, then the employment of both hands is of great service.

The uterus is held in the double hand as well as the abdominal parietes will permit, and gently compressed, from the fundus downward. This plan has been found of much help to assist in the expulsion of the child; and it also is an excellent plan to cause the expulsion of clots after delivery of placenta. After a few minutes trial, examination should be made *per vaginam*, and then should no descent have occurred nor hæmorrhage, the process may be repeated. If then no result occur, the hand must be passed within the vagina or the uterine cavity, and withdraw the placenta. 2. Traction on Placenta.—I have already pointed out to you the disadvantage of drawing on the funis in order to bring down the placenta out of the uterus, and, therefore, you will find that I do not describe that as a mode of delivery of the placenta. Yet gentle traction on the funis as an adjunct to other traction is beneficial. If the margin of the placenta has appeared at the os, then the uterus being in action, it may be drawn upon by two fingers, and at the same time firm pressure being exerted from outside, generally the placenta, if not adherent, descends. It should not be violently and rapidly done, but you will find a little help each time the patient respires; and if the hand cannot be spared to press on the uterus, the patient may be told to bear down. However, I prefer the external hand. If you have any suspicion that the placenta is being torn or funis dragged off, it is better to grasp the placenta firmly, and draw it down, or pass the hand into the uterus at once. 3. Removal of the Placenta from the Uterus by the hand. Having greased the outside of the hand pass it into the vagina in the shape of a cone; take hold of the funis and run your fingers along it up to the os, then slip them off the funis on to the inner margin of the os uteri, and run them up until you pass between the uterus and the membranes. Then seek the edge of the placenta, and beginning at the bottom gently mow it from off the uterine surface until you have detached the whole. Some have preferred to begin at the top and work downwards, but you do not get so well-defined a starting-point as when you begin from below. After you have, as far as you know, detached it completely, take hold of the funis and draw the placenta down the hollow of your hand still in utero into the vagina. And before you remove the hand from the uterus pass it all round to see that you have removed every portion of the placenta; if there be any fragments remaining, gently rub them off with the tops of your fingers. Gather these small portions into one, and then allow the now generally contracting uterus to expel it. But from the commencement of the introduction of the hand within the os, the external hand must seize the uterus through the abdominal walls, and afford a counter pressure. Without this it is impossible to act as advised. The vagina outstretched by labour is so yielding that the uterus retreats before your hand, and I have sometimes been surprised to find how far it can recede. On more than two occasions I have found the uterus under the edges of the ribs, and my arm within as far as the elbow. I have had partly to withdraw my arm to thereby draw the vagina in order that the exterior hand may be interposed externally between uterus aad ribs. Slipping and gliding to one side or another, the uterus if contracted is only to be secured by the firm grasp or support of the outer hand, and when the hand has entered, the support and down-pressing of the hand outside can bring more readily the inner aspect of the fundus to the inner fingers. This is notably the case when in a premature labour, or abortion, the whole hand cannot enter. The external hand will be able to indent the fundus as to bring each portion within reach of the tips of the inner fingers.

If the uterus be relaxed another difficulty generally presents itself; namely, the flabby os and cervix can scarcely be distinguished from the membranes. Hence it is important this point not to be careless nor confused. And if the body of the uterus be not relaxed, still we often, I may say generally, find that the os and portion of the cervix is so, and it is by no means easy to make out the membranes; and even if made out, to clearly get outside of them and inside the os.

Suppose you have adhesions or indurations, the major part has been removed, but you still have left behind nodules adherent firmly to the uterus. How are you to act? If you try to tear off these pieces you may tear off a piece of the uterus, and have terrific hæmorrhage. It is best to manage it otherwise. *With the ends of the fingers bruise down all these fragments until you have pulpified them pretty completely.* Then you gently withdraw all the portions easily detachable with your hand. The portions left are ultimately removed by the uterus as any other adventitious tissue is taken away in the body. As a clinical fact, it does not go into a putrid condition. It is not always easy to pass your hand into the uterus. Do not go violently to to work. Pass your fingers gently *one* by *one*, and with distinct intervals, and you will soon succeed; of course the uterus is to be supported firmly by the outer hand, as before stated. In the difficult cases, I mean with firmly contracted uterus, it is a vast comfort to the patient to administer chloroform. In the inert and semi-inert uterus this remedy is counter-indicated, as it tends to increase the inertia: but in such cases the removal of placenta is not so painful nor so troublesome. If any doubt at all exist as to activity of the uterus, a dose of secale may precede the inhalation of chloroform. If the uterus be over active, of course the condition is much less anxious than if it be inert. There is no need of haste, we may allow half an hour or even three quarters to elapse, provided there be no hæmorrhage, before introducing the hand. However, the case must be watched, and not left for many minutes at a time. The hand must externally take note that no increase of the uterine bulk clandestinely creep on, showing thereby internal bleeding to be going on. Practically, it will be found that if the uterus be not handled much, except for ascertaining its state, the over-activity subsides, and the placenta is slowly extruded into the vagina. It is only a question of patience; but, of course, should hæmorrhage arise, our rule holds good here as in other cases—*if hæmorrhage occur remove placenta.*

Post-mortem Room.

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On Saturday, Dr. Fagge amongst several others, made the following very interesting post-mortems:—

The first examination was upon the body of a woman, who was for some time in Addison Ward suffering from hepatic abscess. She had been in India some years ago, where she had

contracted dysentery, and had been known to have a large hepatic abscess for some time. Whilst in the hospital Mr. Howse emptied the abscess three times with the aspirator, each time obtaining less pus, but always upwards of three or four pints.

Upon removing the sternum, the right lung was seen to be completely collapsed, and the pleural sac filled with a large quantity of reddish-brown, dirty-looking pus, characteristic —even if spit up through a perforation into the lung—of hepatic pus. By compressing the liver pus was found to ooze through a small hole in the diaphragm into the pleural cavity. The compressed lung had the ordinary mouse-coloured, airless, and tough conditions characteristic of carneous lung. The liver contained a large abscess in the upper part of the right lobe, in which there was a quantity of tenaceous muco-pus. Its wall was not indurated, and showed no signs of having contracted. The liver substance was expanded over the superficial part of the abscess in an edge of gradually decreasing thickness, ultimately lost in a fibrous capsule. This may be taken as evidence that the abscess commenced in the liver itself, and not in any adjoining structure. Many maintain, since hepatic abscess in dysentery is so frequently single, that it is a part of the primary affection, and not due to secondary infection from the ulcerated bowel. The Guy's post-mortem records, however, show that the deduction is of but little value in reference to the etiology of tropical abscess, for they contain instances of single hepatic abscess undoubtedly the result of intestinal lesion. The intestine in this case was difficult to comprehend, for instead of discoloured cicatrices in the colon (the remnants of the supposed dysentric ulceration), that structure was found to be perfectly normal, while the cæcum was a mass of apparently recent ulceration. Apart from the above considerations, there were present two other conditions of pathological interest. The kidneys were in the contracted stage of interstitial nephritis, that is, they weighed about ¾lb., normal weight, the capsule of each was somewhat thickened and adherent to the cortex, which showed a granular surface upon stripping off the adherent capsule. The organ, as a whole, was pale and tough. Upon section, the cortex was perceptibly wasted and irregular, the pyramids of Ferrein being, for the most part, lost. A few small cysts were scattered about, and the arteries stood out with undue prominence, owing to the abnormal thickness of their walls.

The other point of interest was in connection with the uterus, which contained several so-called fibrous tumours—that is tumours of unstriped muscular fibre. Several were following the ordinary course of such tumours by escaping from the wall of the uterus, to become pedunculated growths reaching into the peritoneal cavity; and one on the opposite surface forming a fibroid polypus of the uterus. While another, the largest, followed a rarer course, it was undergoing caseation, and in time its existence would probably only have been marked by a little mass of calcareous matter.

The second case was a child, about five years old, who died on the third day after admission, it having been in a more or less collapsed state all the time. All that was made out was albuminuria with granular casts, and a history of recent diphtheria. The naked eye appearance of all organs showed nothing abnormal, not even in the kidneys. Dr. Fagge explained that, though uncommon, still fatal collapse after apparent recovery from diphtheria was a result to be prepared for, and narrated a similar case that had occurred to to him in private practice. Microscopic examination of the kidneys in the fresh state shewed young cells in some of the convoluted tubes, in others the epithelium had become granular and caked up in the middle of the tube-like casts, while a number of others appeared perfectly healthy.

Out-patient Room.

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Malignant Growth Involving the Left Kidney and Supra-renal Capsule of a Child æt. 17 Months.

P. B., female, æt. 17 months. Until seven weeks before death the child was good tempered, could talk and run about. At this time it began to be fretful, to lose its appetite, and refused to lie on its left side. Shortly, it began to waste, while its abdomen increased in size, and a little diarrhœa set in. The mother took it to a doctor, and it was treated for "consumption of the bowels." Not improving, she brought it to the Medical Out-patient Room, where it passed to the care of the junior House-Physician. It had now been ill three weeks, its abdomen was considerably enlarged, and apparently tender; no fluid could be made out, but an irregular tumour was felt occupying a large part of the left side of the abdominal cavity. The lymphatic glands were not noticeably enlarged, but the limbs were much wasted, and its face was pale and old-looking, with pinched features. No rachitis was present. During the remaining few weeks of its life nothing of note occurred, its appetite became worse, it was sometimes sick, it wasted very rapidly, the tumour at the same time getting much larger. Its eyes became sunken, the surface of the body having a blood-less appearance, and died completely exhausted with extreme anæmia.

A distinct history of cancer in the grandmother on the mother's side was obtained; there might have been other instances in the family; the history was somewhat doubtful upon this point.

A post-mortem was made at the patient's residence. The viscera were all found to be healthy, with the exception of the left supra-renal capsule, which was entirely lost in an immense tumour filling three-fourths of the abdominal cavity, and the left kidney, which was infiltrated with the same. The growth seemed, for the most part, to be behind the peritoneum, spreading up into the mesentery, and infiltrating the lumbar glands; but not extending through the intestines or spleen, though the latter, with the descending colon, was adherent to the mass. Two or three ounces of blood-stained serum were contained in the abdomen, but there were no adhesions beyond those already mentioned. The organs were all extremely anæmic. Upon section, the tumour was soft, juicy, of a pinkish colour, with numerous minute extravasations of blood; and arranged in large rounded masses with here and there yellowish portions, which were becoming caseous. The oldest part was evidently at the upper part of the kidney and the region of the supra-renal capsule. The kidney itself was involved from within, the cortex being expanded and healthy at the extreme outside. The whole weighed two pounds. Microscopically the growth proved to be a small round-celled sarcoma, the cells being almost the only structure visible; a faint stroma, however, was present.

Correspondence.

THE LATE MR. RIGBY-HUGHES.

To the Editor.

Sir,—As one of the oldest of the many friends who mourn the loss of poor Rigby-Hughes, allow me to add a few facts that may be of interest.

A sister and a widowed mother deplore his awful death. He was educated in Westmoreland; at school he behaved admirably, and at home he was all that a son and a brother could be. In 1864 he entered at Guy's; he was medical ward clerk to Dr. Gull and dresser to Mr. Cock. Appointed resident obstetric, ill-health drove him abroad, ere he could fill the post. In 1869 he held some post at the Evelina Hospital, and on the 29th of December he started as surgeon to the steamship *Hibernia*, engaged in laying a cable between Aden and Suez, and between Lisbon and Falmouth in 1870; later in this year he sailed in the same ship for Batavia and Singapore, the intense heat of the latter place, 135 deg. F., suiting him admirably. In April, 1871, he returned, and in May he entered at Aberdeen. There he worked tremendously hard, and he would have graduated in April, 1872, but the rigors of a northern winter brought on two attacks of urinæmia; on each occasion he had forgotten all that he had learnt in the previous six weeks. Undaunted by these sore disasters, spite of feeble health and failing sight, he graduated as M.B. and C.M. with highest honours. He also received a special prize in Surgery—a prize rarely given to qualified men, but awarded to him for his great knowledge. In the end of 1872 he filled the post of Resident Obstetric at Guy's, which two years previously his health had prevented him from accomplishing; at this he worked with wondrous energy, sitting hour after hour, writing out elaborate reports. Since then he has been frequently at sea—always paid off with certificates "Very good."

Rigby-Hughes' strong point was his dissecting. This was really noteworthy. Few, very few, have equalled him. His dissections were marvellous by reason of their perfect accuracy and intense clearness; in Aberdeen they caused quite a sensation. By the happy combination of much natural ability and an unbounded capacity for work he had acquired a thorough and complete knowledge of every branch of his profession. He was "splendidly well up." In Aberdeen the professors praised him most highly.

Usually he bore his misfortunes with calmness, and often with high spirits, but all his high hopes in life were early blighted by the development of his dread disease.

His delightful power of talking, his charming stories, his graphic descriptions, with their artistic touches, his unvarying good nature, and his readiness to do a kind act—procured him a large circle of friends at Guy's and at Aberdeen. Very few men could boast so many true friends, few indeed would be so deeply and so widely lamented.

He knew his disease was steadily gaining ground, yet he calmly, fearlessly awaited the end.

Almost on the spot where last year his friend, poor Frank Lungley, was crushed to death in a gale, Rigby-Hughes went gallantly down to his death with his brave, calm captain.

May all Guy's men, in hours of peril, act as nobly and as fearlessly as did these two men, who met their fate in the same troubled waters. Yours &c., Æ.

Report of a Case.

A. C., æt. 11, a well-formed healthy boy, struck his chin with a vaulting pole, nine weeks before admission, and struck it again about a week after. After the blow a painful lump appeared on the chin, and gradually increased, the pain, however, disappearing. The front teeth of the lower jaw were loosened, and removed one by one.

When seen shortly before operation, the external appearances, as well as those within the mouth, were very remarkable. The chin projected forwards, and the lower lip was evidently bulged out by something behind. A bony margin could be felt running along the lower margin of the chin, but behind this, in the sub-maxillary region, was a softer rounded mass perfectly fixed to the jaw. On depressing the lower lip, the alveolar process showed a continuation of the swelling, while the front teeth were gone except one bicuspid, which was quite loose. Their site was occupied by dark, pulpy mucous membrane, which was spread backwards over a tumour which corresponded in consistence, size, and position with that felt below in the sub-maxillary region.

Mr. Bryant operated, on November 3rd. An incision was made along the lower margin of the jaw, three inches in length, the structures in front of the chin were separated by passing the point of the knife behind them into the mouth, similarly the attachments behind were separated from the back of the tumour, except those of the genio-hyoid and genio hyo-glossus muscles. Next the chain-saw was used, to divide the bone vertically on either side, a tooth on each side having been first extracted. When the bone was divided, the remaining soft attachments were cut. It was thought that a small piece of growth remained on the divided end on the right side, so it was removed by the gouge.

The boy's physiognomy was somewhat improved directly after the operation. There was considerable bleeding after he was put to bed, and for some days there was pain and tenderness on the right side of the face. But the pain did not continue long. The external wound soon healed, and the internal commenced to granulate. On the fifth day he was able to protrude his tongue half an inch from his teeth. At the end of three weeks he went home. At that time he could speak intelligibly, though he mumbled somewhat. He could not extend his tongue horizontally forwards, but it went forwards and downwards a long way from his lips. There was no sinking of the chin, and the usual rounded appearance of the integuments was restored, although the chin, as a whole, was rather square. When he smiled his lower lip turned in. There was no frænum linguæ or gum; the upper part of the divided ends of bone were wide apart and covered with mucous membrane, but the lower part was filled in with a bridge of firm new tissue. The teeth of the lower jaw behind kept perfect opposition with those of the upper, and he was able to eat anything.

The growth was enclosed by a thin shell of bone in front behind and below, but above it was not enclosed. The naked eye and microscopical appearances were characteristic of myeloid.

Drawings of the tumour were taken, by Mr. Hurst, both before and after the operation.

He presented himself on Dec. 14th in good health, but a small piece of necrosed bonewas working its way out.

THE TITLE OF "DOCTOR."

In the columns of the *British Medical Journal* there has been raging, for some time past, an angry battle between the Licentiates of the various Colleges of Physicians and the Graduates of the Universities, The former, and especially the licentiates of the Royal College of Physicians of Edinburgh, claim the right of prefixing to their names the title of Dr., and to this the M.D.s of the several Universities think they have a right to object. The title is coveted, because it is supposed to be a sign of distinction, and an M.D., who has spent six or seven years in obtaining a very difficult degree, naturally feels hurt when he finds a fellow-student, who worked only half the time to obtain a medical licence, in practice beside him with Dr. on his door-plate. The Edinburgh College of Physicians has undoubtedly encouraged the belief that their licence confers the title of Dr., and we have known many students from this hospital drawn across the border by the laudable desire to style themselves "Doctors;" moreover, if we are to believe some of the writers in the *Journal*, one or two licentiates have received letters from the Secretary of this College to assure nem that they may so style themselves. Legally, it appears, a licentiate of any College of Physicians has a right to the title of *physician*, and hence arises the difficulty; for, if "physician," why not "doctor?" This is a question which presents itself to both the medical man and his patients, and the former answers it by putting Dr. on his door.

So far, we have stated the case rather from the university graduates' point of view. The licentiates, on their part, complain that the examinations for many M.D.s are not more difficult than for the licences, and the acquirement of the M.D. is a mere chance, due, in a great measure, to original choice of school or city in which to commence the study of the profession. They further state that in calling themselves Drs. they do not take the title of M.D.

The general public, unaware of these contentions, regard the title from an entirely different stand-point; and, as it is in order to gain the confidence of the masses that the ambitious practitioner makes a journey to Scotland to acquire an M.D., or passing a College of Physicians assumes the style of Dr., it will probably be the laity and not the profession who will determine the future usage of the title. Half a century ago, when university graduates were less numerous than now, the title of Dr. was almost peculiar to consulting physicians, but a continuous increase in the number of M.D.s in the profession has led the public to confer upon other members of our profession the general title of 'doctors.' So much, indeed, have we monopolised this distinction, that a Doctor of Divinity is ever in risk of being questioned as to his knowledge of medicine. It is customary now in the highest classes of society, always to introduce a member of our profession as Dr. ——, and this, no matter whether he be simply L.S.A., a consulting-surgeon, or physician. This is done partly out of courtesy and partly for convenience, since it allows the hostess to state the position of her guest, who for the rest of the evening will be mistaken neither for a young lord nor a neighbouring curate. Among the poor also, Doctor and Surgeon are synonymous terms. It is probable that, in future, the custom of styling medical men Drs., irrespective of their degrees, will become more common than at present. The suggestion of Dr. Brown, of Rochester, may serve to settle, for a time, the differences between licentiates and university graduates, viz., that whilst both sections are addressed Dr., in the case of the latter the title should be reduplicated by adding M.D. After all, the actual prefix matters little, for in applying for medical appointments every degree finds its proper level, whilst in practice personal qualities rather than diplomas or certificates determine the success of the individual.

Operations.

Dec. 2nd.—A little boy was admitted into Cornelius Ward suffering from a crushed humerus, the result of being run over by a tram-car. There was no alternative but amputation. Two side skin flaps were made, and the boy was left with a short stump. There was rather severe collapse after the accident, but he is now doing well.

A woman was brought up at night suffering from strangulated femoral hernia. Operation was immediately resorted to by Mr. Howse, as the bowel had been nipped for about sixteen hours. The contents of the sac were not in a satisfactory state, the gut being very dark in colour. Patient died on Tuesday.

Dec. 4th.—Mr. Howse amputated the arm of a patient in inner Samaritan. He was admitted some weeks ago, and found to be suffering from acute necrosis of the fore-arm. On account of the state of the parts only one long outside flap was taken. The hæmorrhage was exceedingly troublesome, and much time was expended in stopping the bleeding. For not only were the bleeding points very numerous, but the arteries also were in a bad state. Torsion was not employed, but ligatures applied.

Mr. Howse excised a knee-joint. The patient was a girl from Charity Ward suffering from disorganization of the joint. The operation was performed in the usual way, but after operation, chloroform was continued in the ward, and the leg packed in a moulded iron splint by means of cotton wool soaked in paraffin, a space, of course, being left so that the wound may be dressed.

Dec. 7th.—Mr. Howse operated in Charity Ward for strangulated femoral hernia. The period of strangulation was comparatively short, and the bowel was in a very fair state. Up to the present time patient is doing very well.

Dec. 8th.—A patient suffering from epithelioma of the the angle of the mouth was operated on by Mr. Powell, the dresser. The knife was carried around the growth, thus enlarging the oral apertures. The cut surfaces were afterwards accurately brought together by sutures passing through the skin and mucous membrane.

Mr. Bryant brought a patient into the theatre who was suffering from an injury to the hip. He had for some time been suffering from "rheumatism" in the leg, which rendered him rather lame. Some weeks previous to admission he had fallen down, and in doing so had strained and hurt his hip. Since the accident the pain had increased, and the trochanters had become markedly enlarged, suggestive of inflammatory mischief. The increase in size and the almost total loss of power in the limb caused Mr. Bryant to suspect the presence of a new growth; consequently a long vertical incision was made over the trochanters, and the soft parts having been detached, the upper part of the femur was exposed, which was seen to be involved in a hard mass of new growth. The head, neck, and a few inches of the upper part of the femur was therefore excised. The bone was sawn through with very great difficulty, owing to the ivory-like nature of its structure. The ligamentum teres and acetabulum were involved, and as much as possible of this having been cut away, a hot iron was applied to the remainder. The bleeding having been arrested by torsion, the wound was dressed.

Mr. Bryant operated on the tibia of a child to remove a

bony tumour. This was easily effected by means of a chisel and mallet. The tumour was sessile, and appeared, on external examination, to be periosteal origin.

The next case was a strangulated femoral hernia, operated on by the House-Surgeon. Strangulation had existed for one week, and the bowel was found to be almost adhereat to the sac. The patient has subsequently died from peritonitis, which existed previous to the operation.

Mr. Howse amputated the thigh of a patient, on whom, some months ago, excision of the kcee had been performed. lardaceous disease, however set in, and it was thought best to take off the leg.

Mr. Howse next amputated the thigh of a patient suffering from disease of the knee joint. Patient has since died with pyœmic symptoms.

Sports.

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FOOTBALL.

GUY'S v. CARLTON FOOTBALL CLUB.

The first fifteen paid their last visit of the season to Victoria Park, last Saturday, to oppose the Carlton Club. Play did not commence until late owing to the non-appearance of several of the Carlton men. The game was very even, and no decided advantage was gained by either side, Guy's scoring two touchdowns to their opponents' one. The feature of the match was a splendid run by Maclean, in which he passed all the Carlton men but one, who collared him close to the goal. There was only time for forty minutes' play. Guy's team :—Keer and Welchman—backs; Breach—three-quarter backs; Maclean and Finch—half-backs; Pinching (captain), Duke, Hetley, Bonsor, Gilbert, Wallis, Carey, Reader, Mansell.

ROYAL COLLEGE OF SURGEONS.

The following paper was set at the recent primary examination for Diploma of Fellow :—

1. Describe the Receptaculum Chyli and Thoracic Duct, including their structure and relations to adjoining textures; and mention the points of entrance into the duct of its chief tributaries.

2. Describe that portion of the under surface of the Base of the Skull which is bounded in front by a horizontal line drawn through the roots of the Pterygoid plates, and behind by a line between the points of the mastoid processes; and then mention, in their order from before backward, the several structures in direct relation with it.

3. Describe the functions of the Medulla Oblongata, (1) as a conductor, (2) as a nerve-centre; and state the facts and arguments upon which your description is based.

4. At what period of Embryonic life does the formation of the human Kidney begin? Describe the process of its development, from the commencement to the completion of the organ; and state when the various changes occur.

Obstetrics.

Statistical Report of the cases attended in the Charity during November, 1874.

Number of women confined	211
Single births	210
Double births	1
Total number of children	212
Of the children born there were living males ...	102
,, ,, dead males ...	6
,, ,, living females ...	100
,, ,, dead females ...	4
Total	212

Presentations :—Vertex, 203; head and funis, 1; hand and head, 1; shoulder, 1; breech, 5; foot, 1. Total, 212.

Operations :—Long forceps were once used, and version was twice performed.

There were three maternal deaths : 1—puerperal convulsions; 2—Pleuro-pneumonia; 3—Acute bronchitis.

Of the women confined there were—

In the 1st confinement	36
,, 2nd ,, ...	30
,, 3rd ,, ...	25
,, 4th ,, ...	22
,, 5th ,, ...	24
,, 6th ,, ...	24
,, 7th ,, ...	16
,, 8th ,, ...	13
,, 9th ,, ...	9
,, 10th ,, ...	6
,, 11th ,, ...	3
,, 13th ,, ...	1
,, 14th ,, ...	1
,, 16th ,, ...	1
Total	211

Of the gentlemen attending Midwifery :—

Mr. W. Kidd attended	23
Mr. J. Mackern ,, ...	31
Mr. A. Bowen ,, ...	36
Mr. J. Brett ,, ...	41
Mr. W. Gathergood ,, ...	50
Mr. Chadwick ,, ...	30
Total	211

The Annual Concert of the Guy's Glee Club, in aid of the Samaritan Fund, took place on Thursday last, Dec. 17. A full account will appear in our next.

THE PATIENTS' CHRISTMAS DINNER.

We have been reminded that it is not left to the students of the Hospital to provide for the in-patients a Christmas dinner. This has long been supplied by the Governors out of the funds of the Hospital.

We regret exceedingly that this was mis-stated in our last number. For just as the authorities of the Hospital take pride in the provision of the beef and plum-pudding, so do the students in the dessert and other good things which they are enabled to provide.

The following is a list, as far as at present completed, of the subscribers to the fund for supplying dessert, tobacco, &c., to the patients in the hospital on Christmas day:—

Subscribers of 5s. each.—Residents during the past year.—Messrs. H. Evans, Powell, H. N. Smith, Reynolds, Rudd, A. H. Jones, Paul, Hobson, Harsant, Branfoot, Hetley, Chicken, Forty, Lees, Wilding, Ferrier, Field, Tyson, H. Duke, Gibb, Manser, Richardson, Mitchell, Bond, Ockenden, Clarke, Fry.

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We hope that all gentlemen wishing to subscribe will at once communicate with the House-Physician or House-Surgeon, as the list must be shortly closed.

DEATH.

We regret to hear of the death of Mr. W. Ernest Snook, a fourth year's student, aged 22. We have not yet heard particulars of this sad event.

The Wards.

—o—

MEDICAL.

The following Cases were admitted between Dec. 9 and Dec. 16:—

Addison—31—Pyrexia. 33—Phthisis.

Mary—17—Laryngeal Phthisis. 26—Malignant disease.

Stephen—8—Phthisis. 16—Heart disease (mitral regurgitation). 18—Chronic bronchitis. 20—Heart disease. 32—Chronic bronchitis. 47—Rheumatic endocarditis. 46—Phthisis.

Philip—3—Capillary Bronchitis. 8—Bronchitis. 25—Emphysema and bronchitis. 47—Bronchitis.

Bright—1—Hysteria. 4—Rheumatism. 10—Morbus cordis.

John—9—Pleurisy. 10—Aneurism of aorta.

Miriam.—20—Laryngitis. 22—Enterica. 23—Enterica.

SURGICAL.

The following cases were admitted between Dec. 9 and Dec. 16:—

Cornelius.—No admissions.

Lydia.—5—Disease of foot backwards, and fractured tibia and fibula. 19 (i).—Comminuted fracture of skull. 19 (ii)—Fractured tibia and fibula. 24—Fracture of tibia and fibula. 25—Disease of hip. 26—Fractured thigh.

Martha.—3—Cut head. 14—Incipient hip disease. 19—Fractured ribs.

Charity—No admissions.

Dorcas—8—Fistulæ in ano.

Luke—11—Perineal abscess.

Naaman.—5—Old amputation of hip. 20—Disease of wrist.

Lazarus.—No admissions.

Astley Cooper—9—Fractured tibia and fibula. 10—Broken ribs. 28—Hæmatocele of cord 29—Ulcers of leg. 30—Fractured fibula. 31—Rupture of Vas-deferens. 32—Abscess about hip. 38—Hæmorrhage from facial artery.

Job.—3—Fractured tibia and fibula. 5—Lacerated wounds of face. 6—Fractured tibia and fibula. 17—Stricture. 20—Fractured fibula. 23—Fractured neck of thigh. 23—Old dislocation of elbow.

Emission of Carbonic Acid by Leaves.—The phenomena of decomposition of carbonic acid by leaves under the influence of light is well known. The inverse phenomenon, that, viz., of absorption of oxygen, and emission of carbonic acid in the dark, has attracted much less attention. M.M. Deherain and Moisson have just communicated to the Paris Academy an interesting memoir on the subject. They find from experiment that the quantity of carbonic acid emitted by leaves is comparable to that furnished by cold-blooded animals; frogs give, in respiration, a quantity of the gas much below that from leaves of tobacco, or mustard, or sorrel. The quantity that leaves emit increases with the rise of temperature, and at 59 deg. Fahr. (it is stated) the respiratory activity of silkworms is comparable to that of decayed leaves observed at 86 deg. Fahr., but considerably higher than what these manifest at 59 deg. to 68 deg. Fahr. Leaves kept in the dark, moreover, absorb more oxygen than they emit carbonic acid, and they continue to emit carbonic acid in an atmosphere deprived of oxygen. When carbon burns and gives carbonic acid, a certain quantity of heat is brought into play, and that heat is utilised, according to M.M. Deherain and Moisson, for the formation of vegetal matter necessary to the growth of the plant.—*London Medical Record.*

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Guy's

Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 13. SATURDAY, JANUARY 2, 1875. TWOPENCE

Owing to the Christmas Vacation the GAZETTE *was not issued last week. We beg to remind our fellow-students that subscriptions for ensuing three months are now due, and should be paid to one of the Presidents of the Physical Society before our next issue.*

WE are impelled to call the attention of our subscribers forcibly to an impending trouble, for a trouble, we regret to say, is the collection of the quarterly subscriptions, and of how serious a nature to the subscribers none but those who voluntarily bear the burden of collecting can tell. They, indeed, have full opportunity to observe a common propensity of human nature—for, surely it is gross selfishness in a man who grumbles freely enough if his *Gazette* be not punctual, if he require to be hunted up and asked for his subscription instead of paying it, when due, to one of the Editors. On the other hand the subscribers also have an opportunity to observe, but then, unfortunately, they are not so observant, or they would see how unpleasant a duty it is, after giving a quantity of time in the production of the paper, to undertake the drudgery of hunting up subscriptions, to say nothing of the uncivil manner in which the modest question "Do you wish to subscribe to the *Gazette* this quarter?" is sometimes answered. Perhaps we have been led to put the case somewhat forcibly, but we have good reason to do so, though many of our fellow-students appreciate our delicate position. Surely our readers by this time understand that the *Gazette* is in the hands of the Presidents of the Physical Society, and that they give their time—so hardly spared by senior men—to it. Perhaps some fear that we are amassing wealth from the proceeds of the *Gazette*, and grudge us our good fortune! Indeed we are at a loss to reconcile amongst Guy's men the loud call for *Gazettes* with the quiet repose in their owners' pockets of so many subscriptions. "Oh!" they say, "I shan't pay till I am asked." What! Guy's men waiting to be asked for what they owe!

Fellow-students! we look to you for a warmer sympathy. We depend upon you for the success of the new year. We rely upon your far-famed *ésprit de corps* to maintain that which your Treasurer and Staff have considered worthy of your most earnest support—*The Guy's Hospital Gazette.*

ALTHOUGH to many Christmas is undoubtedly a season of pleasure, to others it is equally a time of hard work and annoyance. There are some of both classes at Guy's. There are those to whom it has been every one's endeavour to bring happiness, and others who have been hindered by excess of work from sharing in its festivities. The desire for providing a cheerful Christmas dinner for others has prevented many from partaking of their own. But these eat of a nobler feast, and their minds are satisfied with good deeds. We were pleased to see that the patients appeared to enjoy their Christmas, and to forget for a time that they were sufferers in a hospital ward.

The Concert passed off pleasantly and well, and, considered from a financial point of view, was a decided success. The length of the programme was lost in its excel-

lence, and the freshness of the rendering gave a new life to some of the old glees. The very fact that the object of the Concert is to aid the Samaritan Fund ought to ensure its success, and we think that if a Ball with a like end in view were arranged, it would meet with an equal amount of support. The experiment is well worthy of a trial, and, if well managed, would probably prove to be a good speculation. If there was a defect in the attendance at the Concert, it was in the small number of students there; this is apt to give an impression that the support chiefly comes from the *friends* of those connected with the Hospital. We would hope to see this remedied next year.

The decorations in the wards are pretty, and very creditable to those engaged in forming them, considering the shortness of time which was allowed for the arrangement, and the fewness of the hands employed. It may be well to remind the students, though too late for the present season, that they have not displayed that energy in the decoration of the hospital which they have been accustomed to do. Ward-clerks and dressers should take a pride in the decoration of their individual wards, and help the sisters and nurses in the work of holly and evergreens.

In conclusion, we hope that our readers have spent a very merry Christmas, and that next year they may again assist the patients of this hospital to do the same.

ON Monday evening, about six o'clock, a fire was observed by some nurses, in one of the hop warehouses belonging to Guy's Hospital, in Great Maze Pond and filled with a valuable stock of hops—estimated between £30,000 and £40,000—the property of Messrs. Latter and Co. The discovery was at once communicated to Dr. Steele, who sent for fire-engines, but others were at work before these arrived. An attempt was made at first with the hand-machines to extinguish the burning hops before the building caught fire, but without success. One fireman was somewhat hurt in the fall of a quantity of hops, but not sufficiently seriously to stay in the hospital. The fire rapidly gained ground though played upon by every available hose (several of which were attached to hydrants, the property of the hospital), and in time the roof fell in, when volumes of smoke and flame burst forth, the latter reaching perhaps fifty feet in height. The wards of the new wing were filled with smoke to the danger of several bad chest cases, and, owing to the wind blowing the flames in the direction of the hospital, it was thought that something worse than smoke might find its way to the adjacent wards, therefore the Treasurer ordered the removal of the patients from Mary and Stephen to the opposite wards. But the fire was completely subdued by ten o'clock, and we had nothing worse than smoke to contend with. That, however, was bad enough; and it was noticeable that cases of bronchitis and heart disease with dyspnœa were most affected by it, while phthisis cases were scarcely at all inconvenienced, and none were particularly worse the next day. One or two deaths may be said to have been hastened by the smoke, especially one of mitral stenosis and regurgitation.

The warehouse was well insured against fire, so that the cost of rebuilding will be completely covered.

The following appointments have been made by the Treasurer:—House Physicians—Messrs. Fry, Clarke, and Tyson. House Surgeons—Messrs. H. Williams, Forty, and Harsant.

At the recent examination for the Second M.B., at Cambridge, Mr. E. Amphlett, M.A., was among the successful candidates.

CHRISTMAS IN THE WARDS.

Christmas in the wards passed off this year in the usual joyous manner.

The patients were all supplied with a dinner of roast beef and plum-pudding provided by the Governors of the hospital, followed by dessert supplied by the students, the fund for which amounted to £22 12s. 6d., about 9d. per bed.

In the male wards smoking was permitted this year by all the sisters, and, we believe, that this boon was valued at least as highly as any of the luxuries. In the evening the convalescent patients gathered round the tables and sang songs, and, having thoroughly tired themselves, finished the day with a sumptuous supper.

The decorations in many of the wards showed excellent taste, and did great credit to the nurses, who worked very hard to make them look beautiful. It seems invidious to mention any particular wards when all looked so nice, but Clinical, Luke and Martha struck us as being the most elegant.

Many of the physicians and surgeons cheered the hearts of their patients by seasonable gifts, among which we noticed a great number of toys for the children, and in one of the wards there was a gorgeous Christmas tree.

We must not omit to mention the decorations of the Chapel, which deserve all praise. It has rarely fallen to our lot to see church decorations done so prettily or in so

good taste. The highest praise is due to the ladies who, we understand, were principally engaged in them.

The following additional subscriptions were received towards the fund for providing dessert for the patients on Christmas-day :—

SUBSCRIPTIONS OF 5s. EACH.—Messrs. T. Eastes, J. Rendall, R. C. Richards, W. Brown, Ransford, and Amphlett.

SUBSCRIPTIONS OF 2s. 6d. EACH.—Messrs. J. Davies, Key, J. Briscoe, Penny, T. Duke, Boughton, Maclean, J. H. W. Jones, Routh, W. J. Coles, Wooldridge, T. A. Richardson, G. Davis, Morse, and A. Carey.

GLEE CLUB.

The Guy's Glee Club gave their annual concert in aid of the Samaritan Fund, in the Governors' Court Room, on Thursday, December 17th. The attendance was not quite so large as usual, owing perhaps to the inclemency of the weather. The concert opened with a glee, entitled "Lordly Gallants," which was sung correctly, but with scarcely sufficient spirit. Mr. Stanley Taylor, who made his first appearance as a solo singer in these concerts, gave a little song, entitled "Twilight is Darkening," which was followed by Scotland's extremely pretty glee, "Lightly Tread," very well rendered. We admired much a "Meditation" of Bach's, played with great taste and effect, on the violin, by Mr. C. E. Bell. We cannot but congratulate him on his improvement, both in tone and execution, since we last heard him. In the second part of the programme he gave the by-no-means easy selection from "La Fille du Regiment," which deservedly received an *encore*. A trio, "Queen of the Night," was sung by Messrs. Taylor, Wright, and Rudd; this, with a glee, a part-song, and a solo, "The Song of the Old Bell," brought to an end the first part of the concert. We must not omit to mention a quaint little glee, entitled "Onward Roaming," which was given with great effect. Mr. Wright's very pleasant voice, and charming interpretation of "The Mariner," both demanded and received a unanimous *encore*, but he substituted, and sang with great feeling, "Bid me to Live." The grand part-song of Arthur Sullivan, "The Beleaguered," received the fine rendering it fully deserves. The ancient and amusing glee, "Dame Durden," was given humorously. "Love and War," a duett, was sung by Messrs. W. G. Gray and J. H. Poland. "The Vintage Song," which pleased as much as ever, both as regards the music and its execution, was followed by an appropriate part-song, "The Watchman's Song," which, with "God Save the Queen," brought the concert to a successful termination.

A STUDENT'S NOTES OF

Lectures on Midwifery.

By J. BRAXTON HICKS, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

LECTURE IX.

POST-PARTUM HÆMORRHAGE.—If, however, hæmorrhage continue after the removal of the placenta, or if it begin after its removal, what are we to do? Two questions thereupon arise: the first is, what are we to do for post-partum hæmorrhage in general? the other, by what means can we guard against the recurrence of this calamity in those who have in former confinements suffered from it?

First, then, let me consider how can we arrest post-partum hæmorrhage.

Before we do so, let us clearly understand what is the clinical condition with which we have to contend.

The most common, doubtless, is an uterus more or less uncontracted. The causes of this condition are many, but they may be resolved into two major classes: one, in which the uterus, from a long labour, or from a readily exhausted nerve-power on the part of the patient, is tired out and used up its contractility, a state of things very frequently seen after craniotomy, etc.; the other, where the uterus has not been sufficiently excited, either the child has been withdrawn too quickly, or it has been expelled with too great ease. Any how, there has not been irritation or pressure sufficient to keep up the proper amount of reflex action after the placenta is delivered.

But, how much contraction is needed to prevent hæmorrhage? Certainly the most secure condition is the little hard uterus likened to a cricket-ball. But it has not so rarely happened to me, and from conversation I find the same has also to others, that an uterus may be anything but hard and firm, and yet no hæmorrhage may result. I presume that there is a degree of contraction sufficient to arrest blood-loss, short of the hard and most desirable state. I think also much depends on the size of the sinuses patent on the inside of the uterus, a variable condition, as variable, indeed, as varicose states are. Probably something may be owing to the state of the vascular system, both on the left side and the right side of the heart; and, again, something may be found to explain in the power of the abdomen called by Dr. M. Duncan "retentive," which, although much neutralised by the flaccidity of the walls, yet in some might neutralize the outflowing from the uterus, and this action certainly might be increased if the abdomen were bulky and pendulous, hanging over to the side. However any one, or some of them combined, may be the cause, it is certain that in some cases the uterus is considerably relaxed without the occurrence of flooding.

But, if an uterus be contracted and in an active condition, this does not necessarily ensure immunity from flooding; for, if it be distended by a piece of placenta, or a clot, or anything, or if it be prevented from well closing, as by a distended bladder, as was pointed out by the late Dr. Lumley Earle, or from adhesions, as remarked by Dr. Graily Hewitt, in any case, hæmorrhage is pretty sure to arise, unless the uterus be in powerful action.

What a common case is this. A small clot, formed,

perhaps, before the extrusion of the after-birth, is not expelled; the uterus, notwithstanding it is firm and hard, increases in bulk; a slight gush takes place on firm pressure, and some watery blood, or nearly clear serum, flows in small quantities from the vagina. Notwithstanding the firm and even painful contraction of the uterus, it slowly enlarges, and, upon a considerable quantity of blood escaping, the hand is introduced, and a hard firm clot is found. As soon as this is removed, the oozing ceases, and the case is safe; or should the practitioner, ignorant of the import of an increasing though hard uterus, leave the patient, he may be recalled to witness the worst terrors of flooding; for, the uterus having relaxed, all check over the oozing ceases, and the blood pours forth from every stretched out opening.

Another cause occurs at times, and gives much trouble; namely, a partial relaxation of the uterus, an irregular contraction; I mean an uterus contracting on one side only at first, then that part relaxing, and the opposite side contracting, and so on. This state permits a certain amount of bleeding, which, coagulating within the uterus and gradually added to, tends to the dangers common to the presence of clots above-mentioned. These cases cannot, I suppose, be very common: I have seen about three well-marked instances.

Another condition one finds by no means rarely, namely, the alternate relaxation and contraction of the uterus. Of course, this is the natural state of the uterus after labour, but in these the intermissions of the contractions extend to more complete relaxation. A great deal of blood may be lost this way; indeed, I have seen some fatal cases, and very many women who have been in great jeopardy by it. It is, of course, a less anxious state than that of absolute relaxation; but it is, perhaps, more deceptive.

Again, where placenta has been prævia, or near to the uterine opening, we have sometimes a very troublesome loss. For the lower zone of the uterus after labour does not contract well, indeed it is generally more or less relaxed; if on this part the placenta have been inserted, it can readily be perceived how hæmorrhage can arise. But sometimes it arises after placenta prævia, though in a different way. If the bleeding from the vessels be slow, and clots become adherent to the lower uterine opening, the hæmorrhage from the upper part is retained, and danger from flooding thus arises; and I may remark, incidentally, that this blocking up of the uterus, although it may not produce hæmorrhage, yet retains decomposing secretions, and thus adds to the post-partum dangers of placenta prævia.

Hæmorrhage after delivery occasionally occurs from lesions of the uterine walls. The more frequent of these rarer cases is the lateral laceration of the vaginal portion of the cervix. In these the blood is generally bright, particularly in the latter variety.

Lastly, hæmorrhage after delivery may occur from inversion, partial or complete. If incomplete, the cause may be overlooked. I was a year or two since asked to see a case of flooding, and to bring my transfusion apparatus. The patient was dead before I arrived; I, however, passed my hand to ascertain the cause, and found the upper part of the uterus inverted, feeling like a polypus just within the os. I had no trouble in reducing it.

If these causes be duly borne in mind, the principle of treatment is clear enough. If the uterus be inert, we must induce it to contract by the various plans at command; if we cannot do this, we must do what we can to coagulate the blood and to cause a contraction of the inner surface of the uterus by styptics locally applied. If a clot of blood, or fragment of placenta, be the cause, then its removal, either by external pressure or introduction of the hand, or by these two plans together, is the clear indication. If irregular action be present, then our attempts must be directed to ensure a more perfect action.

If lesion be present in the body of the uterus, it is clear it would be highly dangerous to use any styptics if the laceration extended to the peritoneum; but, if the hæmorrhage came from the vaginal portion of the cervix, if cold and pressure failed to stop it, a sponge dipped in styptic and firmly pressed on the rent would be the most sure way of arresting it.

But the categorical account in many text-books of the various modes of checking post-partum hæmorrhage fails to convey the clinical assistance required in the case; because, in most cases, either from the suddenness of the attack or from carelessness of observation, the practitioner is brought face to face with serious loss, and action must be prompt. But is everyone prepared to meet this possibility? How do many go to a case of midwifery? Of course, if, in one's rounds, one be called to a case, complete provision is not to be expected; but when called straight from home, how few take anything with them. Thus, if the bladder be full, there is no catheter; if a languid uterus suggest the possibility of subsequent inertia, there is no secale; and if hæmorrhage actually occur, then the practitioner has to meet it only with cold water and his hands. But, if we thus undertake a case, are we much better than the simple woman-midwife, who is not allowed to use secale, and has nothing besides? No one should go to a case without a catheter, secale, opium, ammonia, a good syringe, and (as far as my present experience has shown me its value) the perchloride (or a kindred preparation) of iron.

When, then, the placenta is delivered, a careful practitioner, instead of leaving the bedside, will take charge of the uterus, either by his own hand or by closely watching his assistant; and also will either keep the vulva in view, which can be done without exposure to any extent, or will frequently examine the napkins; and, if he find the uterus relaxed in part or wholly so, if it be still enlarging, notwithstanding its firmness, or if he see hæmorrhage arise, he is instantly ready to act. He will, however, have already unobservedly prepared measures in anticipation—cold water in plenty, some already poured out in a basin; and broken ice, if obtainable; with the syringe charged ready for instant service. He will have some fluid preparation of secale at hand. If he possess only powder, then he will have already made a decoction. It may be that in ninety-nine per cent. of cases these arrangements will not be wanted. So much the better for the ninety-nine, but so much the safer for the remaining one to have them ready.

But, besides these precautions in ordinary cases, there are some which should be adopted in cases where we suspect, as the case approaches termination, that hæmorrhage may arise. I mean after very long labour, much exhaustion, a languid action of uterus, where the interval between the pains is long, the pain short, but the progress during it rapid. In these cases, it is always better to give secale just before the head comes on the perinæum; and, where the child glides out rapidly with slight pains, it is better to carefully check the descent of the head, so as to rouse the uterus by an impediment. It is also better in these cases

not to hurry away the placenta. Its presence acts as a stimulus to the contracting power of the uterus; and, if the uterus be not expanding, nor hæmorrhage occurring, no reason exists for its removal. But of course the medical attendant must not leave the uterus to any one; it must be under his grasp the whole time; and specially he must not drag on the funis, but be ready, as soon as hæmorrhage appears, and external grasping fails to extrude the placenta, to pass the hand boldly in and remove it. I think that, among the causes of after-relaxation of the uterus, is the removal of the placenta from the hesitating uterus. Of course, if the hand in removal be passed rather roughly, and the internal surface excited by the free touching, it compensates somewhat for the removal; otherwise it, like a premature removal of the fœtus, is apt to leave a flaccid uterus.

Supposing, then, that after the placenta has been delivered, and we have left the uterus in charge of the nurse's hands, or after the application of the binder (which latter has the great fault of concealing rather than revealing) we find the patient pale, and the uterus largely distended, we should instantly pass the hand on to the uterus firmly and quickly, and press it till, the blood having escaped, it is sufficiently small enough to be grasped, which should be done firmly, accompanied by friction of its surface. I always pass the hand into the vagina, and remove the clots; and, if the flooding have ceased, I merely keep up the grasping and friction on the uterus; but, if any hesitation to contraction be present, I apply cold, externally, by the hand or napkin dipped in cold water; at the same time I inject cold water into the vagina. Should, however, these plans fail, or the hæmorrhage be profuse, I pass at once the hand within the uterus, and remove every clot, examining the whole inner surface to see if any portion of the placenta or membrane have been left attached. It seldom occurs but that the uterus contracts and remains so, but, should it relax, I repeat the clearing out (for clots are almost sure to be there), and carry the syringe jet to the fundus and throw in cold water; or, if ice be at command, I carry in a lump and rub the inside of the uterus all over with it; this is generally a most efficient remedy. If the uterus fail to contract or to remain contracted, the condition of the case is very urgent. The hand should be carried in again, and the uterus well titillated; of course, during the whole of this action the exterior is to be firmly grasped. Unfortunately, the blood-loss has lessened the chance of contraction; but, fortunately in very many cases at this crisis, syncope steps in, time is given for coagulation in the uterine vessels, and the patient is saved. It is generally those patients who never faint that die, if we cannot stop the flooding. Only two measures in this desperate state of things, remain to us; the first of which is pressure upon the aorta and vena cava. A diaper can be folded hastily into a firm pad, and pressed on the centre of the abdomen, about the navel; the patient, if not already on her back, should be so placed. I would recommend that the legs be not elevated, because, when the return current of the vena cava to the heart is stopped, if the legs were lifted, the blood would regurgitate to the uterus, and still more be lost. I think this plan should be more frequently adopted than it is. Like fainting, it permits coagulation.

Hitherto, I have been considering the more severe kinds of flooding, where we have no time to temporise, no time for secale, galvanism, and emetics. But in all cases of flooding, where grasping and friction externally, coupled with cold injections into the vagina of cold water, and secale, fail to produce cessation of the flooding, the best and most secure plan is to pass the hand within the uterus, if we break up the clot as far as two fingers can reach, and employ pressure from without. If, however, the bleeding continue, it is shortest to pass the hand inside the uterus, and remove everything which may keep up the bleeding; and if we find no fragment of placenta or adherent clot, we should examine for a lesion. If there be none, and the bleeding still continue, after the application of cold, particularly if there be partial or intermittent relaxation, then we must try aortic pressure; and this failing, our only resource is to apply a styptic to the interior of the uterus. In my own practice, I employ a rather weak solution at first—one of the weaker liquor ferri perchloridi to six or eight of water. If that fail, then I make it stronger; but, if the flooding be rapid, I use the full strength of the weaker solution or the tincture, because much of it is lost in the blood, or is prevented from coming easily into contact with the walls. The tube of the syringe should be carried to the fundus, and the fluid gently injected; or it may be conveyed with a sponge, which should be passed over all the internal surface. Perhaps this is the safest mode; but it must be removed promptly, or the uterus may retain it, as occurred in one case I know. I have tried it in all kinds of post-partum hæmorrhage, after removal of clots, which is important, or they become coagulated and firm, and cannot be removed afterwards without trouble. I have found it particularly satisfactory in cases of irregular and intermittent relaxation, causing the uterus to assume its proper form at once.

I do not enter into the discussion as to how it acts. It stops blood in hæmorrhage from a wound on the outside; I presume it acts similarly on the inner side of the uterus—of course not requiring general uterine contraction. I have no doubt, in the less inert conditions, it rouses the remnants of contraction, and acts as cold and the presence of the hand.

In flagging or inert states of the uterus especially, stimulants must be given in full doses at first; but it is doubtful to my mind whether large quantities should be repeated. I have seen complete intoxication follow without any advantage; on the contrary, I have considered with detriment and increase of depression. The same may be said of secale. Good as it is in its moderate doses, it depresses the heart-action if given in too large quantities.

With regard to the second subject—namely, what can be done to prevent hæmorrhage in "flooders"—of course the answer is, be always prepared as one should be in an ordinary case; but I think it would be well to give secale very early in labour, in small doses, such as ten grains every two or three hours for four or six doses; or to rupture the membranes as early as possible in labour, or even before labour sets in.

I may add one more remark; that, although I do not despise the assistance, when single-handed, of spring-pads, etc., yet I consider that nothing equals the hand, which should never leave the uterus from the actual expulsion of the fœtus till the uterus has continued firm for an hour after labour, or after cessation of hæmorrhage, or even longer after very dangerous flooding.

Physical Society.

—o—

At the seventh meeting of the Society, on Saturday, the 19th inst., Mr. J. H. Poland read a paper on "The alteration of the Temperature of the Body after the Ingestion of Food." Mr. Hetley was in the chair.

Before the reading of the paper, Mr. PEDLEY (due notice having been given to the Presidents of the Society) proposed that any member should be allowed to bring before the notice of the Society any instrument or new invention, the merits of which he wished to have discussed. He said that it was the custom at other societies, and the practice was attended with great benefit, and he thought that its adoption at Guy's would be preferable to the compulsory reading of a paper.

Mr. SYMONDS seconded the motion, which was almost unanimously carried by the members.

Mr. J. H. POLAND then read his paper, of which the following is an abstract:—After a few preliminary remarks, statistics were given of the following cases—in phthisis an average rise of 1° occurred after dinner; in scarlet fever, typhoid fever, and measles an average rise of ·77°, or nearly so, in each case; in diabetes, an average rise of ·45°; in albuminuria, an average rise of ·7°. These were the whole of the medical cases. The surgical cases comprised the following:—amputations, excisions, and venereal, in which the rise after meals seemed to vary with the severity of the operation, the greatest being ·9°, and the least ·6°. In health it was stated that the normal rise was ·5°, but this was subject to variations owing to the nature of food taken, whether hot or cold; also the condition of the person on which the experiment was performed, all those in disease being exposed to nearly the same conditions, the food and heat of wards being similar throughout the hospital. Sex and age influence the rise, as in the female it is slightly less, owing to the difference in quantity of food taken, which was also the same with regard to age, with the addition that old people were not so active as young, and therefore this would also tend to lessen the rise.

Mr. MCCARTHY quoted from the proceedings of the Royal Society to show that the temperature of the body never rose more than a degree after the ingestion of food. His own temperature had risen two degrees after a meal. He found that cold alcohol, beer, and such like stimulants, depressed the temperature. He thought the rise might be attributed to the exercise of eating.

Mr. GREEN mentioned the effects which different substances had on the temperature of the body, and thought that heat absorbed by the body was in some cases simply radiation from the substance swallowed.

Mr. SHADWELL mentioned the influence which climate had, and the variations of observations in the West Indies and England. He gave many interesting personal experiments, amongst others was the fact that he had observed his own temperature rise 2·3 degrees after a large quantity of tea.

Mr. DAVY quoted Mr. Garrod in "Scientific Review," to confirm the statement that the rise of temperature was due to muscular action. He had observed the same rise after rapidly undressing.

Mr. HARSANT thought Mr. Poland had failed to prove the point he had sought to establish. All the temperatures quoted had been taken from patients suffering from some disease. Different diseases required different food, and therefore a variation of temperature was to be expected.

Mr. SYMONDS referred to the experiments of Savory. In temperate climates oleaginous food was required, and the temperature naturally rose after its ingestion. He doubted whether the same result would be obtained if farinaceous food only was eaten.

Mr. A. H. JONES expressed his opinion that the temperature rose and was influenced in degree by the quality and quantity of food.

Mr. E. DUKE believed that the temperature of the body was not influenced so much by the nature of the food as by its actual temperature when taken into the stomach.

Mr. CHICKEN said that the immediate rise of temperature could not be due to the absorption and burning off of fatty material that had been swallowed, as it was not in a condition to be absorbed until three or four hours had elapsed. He believed that tea taken hot increased, but taken cold decreased the temperature.

Mr. CARRINGTON remarked that fat was prepared for absorption in the duodenum, and that it had been seen to emerge from a duodenal fistula a quarter of an hour after a meal.

After some further observations from Messrs. Green, Morgan, and Shadwell, a vote of thanks to the reader of the paper was carried, and the Chairman then announced that at the next meeting Mr. Hobson would read a paper on the "Morbid Sounds of the Heart."

Reports of Cases.

—o—

TWO CASES OF INJURY TO THE SPERMATIC CORD.

F. R., æt 18, No. 28, Astley Cooper Ward. While sitting astride a pole his legs were forcibly abducted, whereupon he felt something give way in his right groin, and in the even noticed swelling, and experienced severe pain in the groin.

On admission, on the third day, there were severe pain and tenderness in the seat of a hard tumour which occupied the right inguinal canal, and projected a considerable distance through the external abdominal ring into the scrotum. In the scrotum it was conical, and the cord appeared to be continuous with its apex; there was very slight impulse on coughing; the cord and testicle of that side were not red nor remarkably tender, but swollen. The bowels had been open on the second day; he experienced no abdominal pain, distension, nor any sickness. He did not pass any blood in his urine. He was sent to bed, ice applied, and all solid food forbidden. After some days his bowels were open without medicine.

On the thirteenth day he was quite free from pain, the swelling of the testicle had subsided, the cord was not much thickened below the swelling, but the swelling itself was as hard as ever, though a very little diminished in size, and impulse was more free on coughing.

T. T., æt 28, No. 31, Astley Cooper Ward.

On Saturday, the 12th inst., he was working with a crowbar, and, upon forcibly extending his right thigh on his pelvis, he felt something give way in his right groin. He noticed

no pain or swelling at the time, but on the next occasion of making water he noticed a little blood at the termination of the process. On Monday also he continued to pass blood. By Monday afternoon there was a swelling without tension in the right inguinal region. apparently occupying the spermatic canal. There was no distinct impulse on coughing. There was swelling and redness with extreme pain and tenderness in the right testis; there was also swelling of the cord. He had no abdominal pain or sickness. He had ice applied, and fluid diet at first. On the 21st all pain had subsided, swelling in groin nearly gone, testis smaller, but cord and epididymis very hard and swollen.

The Dissecting-room.

A few days before the commencement of the vacation, the severe frost gave an opportunity for skating such as has not been enjoyed for some years, and many students availing themselves of this chance caused the Dissecting room to appear rather empty. The extremely cold weather has affected us in another way, for, owing to the greater mortality among paupers, there has been a gradual accumulation of subjects for dissection. There were a good many applicants for "vacation parts"; but, as usual, more names were put down for "heads and necks" than other parts. Six subjects have been sent in during the recess, and we understand that there are as many as twelve more lying ready for gentlemen on their return from the country. Classes for students intending to present themselves for the primary examination at the Royal College of Surgeons have been continued without interruption.

AGES OF SCIENTIFIC MEN.—Judging from the roll of the Royal Society, the pursuit of science does not appear to be detrimental to health. From the death-roll, the total number of deaths. from November 30th, 1873, to November 30th, 1874, was fourteen. Of these, three were under 70 years; five—Sir W. Jardine, Sir J. R. Martin, Professor J. Phillips, Sir F. Smith, and E. H. Stirling—were between 70 and 80; five between 80 and 90 years; and one, Sir G. Rofe, 94 years. Looking at the last five, we see that Sir John Rennie died at 81, Professor R. E. Grant at 82, Sir W. Fairbairn at 83, and Dr. Arnott and the Rev. J. W. Bellamy, each at 86. These are remarkable facts, suggestive of matter for consideration. The present number of the society is 525, of whom Sir Edward Sabine is the father. He was elected a Fellow in 1818, and is the last of the men elected within the decade of the century. Of Fellows elected within the period 1820-29, there remain eighteen who now tak rank as veterans. Among them, we remark the names of Thos. Ball, Dr. Bosworth, Sir John Davis, the Duke of Devonshire, the Earl of Eniskillin, Earl Stanhope, the Dean of Salisbury, Sir J. G. S. Lefevre, Sir C. Lyell, Sir Wood bine Parish, Mr. G. P. Scope, Sir G. Shuckburgh, and Sir R. Vyvyan. In this list of veterans Sir J. Lefevre takes precedence, having been elected in 1820.

The Wards.

MEDICAL.

The following Cases were admitted between Dec. 23 and Dec. 30:—

MARY.—1—Gastric fever. 2—Phthisis. 3—Pycemia (?) 10—Aortic disease.—24—Dyspepsia. Cot.—Chorea. 25—Chronic metritis. 26—Pregnancy—metrorrhagia. 27—Retroversion—(?) fibroid. 28—Ante-version. 29—Retroflexion. 32—Endometritis. 34—Ruptured perinæum. 35—Metritis—sub-involution. 36—Epithelioma of labium. 39—Ovaritis. 45—Hypertrophied cervix.

ADDISON.—4—Bronchitis. 5—Hysteria. 14—Chronic rheumatism. 15—Acute rheumatism. 17—Chronic Bright's disease. 24—Mitral disease 25—Hæmoptysis. 34—Bright's disease. 35—Bronchitis. 36—Bright's disease and bronchitis. 42—Acute hydrocephalus.

STEPHEN—3—Chronic Bright's disease. 14—Phthisis after enterica. 20—Pericarditis.—rheumatism. 30—Phthisis—emphysema—bronchitis—death 31—Tumour of lumbar spine. 32—Anæmia. 37—Acute bronchitis. 44—Paralysis after fractured humerus. 45—Renal calculus.

PHILIP—3—Heart disease—death. 3—Acute rheumatism. 22—Aortic disease. 22—Diabetes.

BRIGHT—1—Hysteria—epilepsy. 3—Left hemiplegia. 4—Acute rheumatism. 8—Facial neuralgia. 10—Acute rheumatism. 13—Mitral stenosis and regurgitation.

JOHN—1—Acute pneumonia. 4—Acute tuberculosis.—4—Chronic Bright's disease. 6—Fits after intoxication. 6—Rheumatic fever. 10—Acute Pleurisy—12—Acute pneumonia. 13—Heart disease.

MIRIAM.—20—Chronic Bright's disease. 31—Acute tubular nephritis.

SURGICAL.

The following cases were admitted between Dec. 23 and Dec. 30;—

MARTHA.—3—Pott's fracture (compound). 5—Femoral hernia. 5—Scalp wound (gone out). 8—Suppuration of palm of hand and wrist. 17—Suppuration about ankle-joint. 18—Stab behind angle of jaw and back of neck. 19—Fracture of tibia and fibula. 21—Fracture of tibia and fibula. 33—Wound of abdomen.

ASTLEY COOPER—1—Abscess in gluteal region. 4—Epulis. 18—Popliteal aneurism. 19—Pott's fracture. 20—Pott's fracture. 34—Fracture of tibia and fibula. 38—Pott's fracture.

LAZARUS.—4—Fracture of tibia and fibula. 7—Scalp wound. 8—Fractured tibia and fibula (Pott's). 9—Fracture of patella. 12—Compound crushed fracture of both legs—dead. 12—Urethral stricture. 13—Sprained ankle. 14—Fracture of tibia and fibula. 15—Fracture of patella. 16—Wound on frontal eminal—hernia. 19—Fractured ribs. 20—Syphilis (?) 22—Fracture of femur.

SAMARITAN.—24—Soft sore and phymosis. 25—Soft sore and phymosis. 26—Soft sore and phymosis.

THE CAUSATION OF SCARLET FEVER.—Dr. J. G. M'Kendrick of Edinburgh is at present engaged in a research on the causation of scarlet fever, of which there is an epidemic at present in Edinburgh. Microscopic examination with high powers reveals, we understand, the presence in the mucus, from the tonsils and in the skin, of minute bodies similar to those discovered by Klein in typhoid fever, and by Klebs in diphtheria.—*British Medical Journal.*

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AMONG the many things which perplex a student or practitioner, on first having to treat patients on his own responsibility, the knowledge of how to prescribe holds a somewhat prominent position. There are comparatively few men, who leave the hospital with the capability of writing a prescription fit to be sent to an ordinary dispensing chemist. Nor can this be wondered at, when we think of the very slight estimation in which this art is now held. It is, doubtless, far more important to understand the action of the principal drugs, than it is to be able to combine a number of things so as to form an "elegant" prescription; but still, it is with a somewhat awkward feeling that a man sits down to write out his first eight-ounce mixture. It is perhaps excusable, owing to the great saving of time it effects both to the staff and dispensers, that in large hospitals the more common combinations should be kept made up in the form of mixtures, but nothing can be more detrimental to the student. In the large majority of cases he sees ordered, and—when he becomes a dresser—himself uses, mixtures, of the contents of which he is in total ignorance. Nothing can be more advantageous to the student, than a discussion with the physician as to the exact diagnosis of any case, and such discussions in our wards are not infrequent. But it is comparatively rare to hear the question of treatment argued in the same way. As a rule, the physician—without any previous questioning—dictates to the clerk, who writes the formulæ on a board, and there the matter ends; whilst the students—more especially the junior men—leave the case without the slightest idea of the principles which guided the treatment, or the reasons which dictated that exact combination. Whether we associate any theory with the administration of medicine, or whether we act empirically, the discussion of the treatment would be equally valuable, and more especially must this be true, if we believe—as we are here more particularly taught—that experience forms our best—in the present state of our knowledge—the only true guide.

A STUDENT'S NOTES OF

Lectures on Midwifery.

—o—

By J. BRAXTON HICKS, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

LECTURE X.

We come now to the most important portion of our course, to which the former is but child's play—interesting and very important to know, because it is impossible, without a thorough knowledge of it, to properly understand the means whereby we are enabled to combat the errors of labour, which will engage our attention for the remainder of the session. If the whole of midwifery were included in what you have already been taught, your anxieties would be slight and your work not very arduous; you would be scarcely more than spectators of a highly interesting physiological phenomenon. But in no case can you be assured that you may not be called upon to grapple with difficulties and to ward off dangers which may tax your utmost knowledge and powers. Some, from their insidious approach, will demand watchful patience; others, from their suddenness, will require energy and promptitude. To manage many a combination of these qualities will be requisite; a

combination of two mental qualities, not so easy to find naturally mingled, yet possible of attainment—at any rate for practical purposes—by careful cultivation. Those of you who, as you all should do, carefully review your own powers, will be enabled to see in which of these points you fail, and by steady practice you will be able to arrive at a result which, if not absolute perfection, will serve you and your patients well in the hour of need. Yet nothing but a full knowledge of the whole subject can make you competent to conduct cases of emergency. There is no time to think; life depends upon moments; your recognition of the cause of danger, and the employment of the means to combat it, must be coincident. But in all this development of energy be as gentle as possible; you have to do with a readily impressible system; and while you are *prompt, be calm.* Your patient watches you; scans anxiously your manner; she quickly recognises anxiety in your face or movements; and if she read it there, something is added to her danger.

Now, abnormal labour has been variously classified. Most authors have made the classes without the same basis, which of course is unphilosophical—for instance, taking time as "Tedious Labour," the next class "Laborious Labour," then "Obstructed Labour," then a fourth "Complex Labour."

The mode of classification may to some of you seem of but little importance, and yet it is of much; for, to be able to promptly treat a sudden emergency, it is essential that we should have a rapid method of recognising its cause. If we take, for instance, "tedious labour" as a class, it is evident that we must wait till its completion before we can classify it. The classification does not help us, but, on the contrary, it rather impels us to wait; whereas, if we notice that the labour is slow because of the weakness of the pains, then our mind is at once directed to the removal of that inactivity. A still further peculiarity of the class "tedious labour" was that authors bargained that the labour should not have been assisted by instruments.

You will, by these remarks, have already perceived that I consider the proper basis of classification to be "cause,"—and this is that which I shall adopt in this course.

But as the length of labour has much to do with the well-doing of the patient, so the knowledge of the effects of "prolonged labour" upon the system is of the utmost consequence. I shall first of all endeavour to point out to you the symptoms which are produced upon the mother by the detention of the fœtus in the parturient passage, and then allude to the effects upon the fœtus itself.

Bear in mind, first of all, this fact: that by whatever cause the fœtus may be detained, when labour has once fairly set in, certain symptoms will arise, which, if unrelieved by nature or art, will go on from bad to worse, till they end fatally. No matter what the presentation, or what the point at which the arrest occurs, sooner or later the patient will succumb unless relieved,

I will not detain you with the seemingly possible exception of what is called "missed labour," because in these cases labour has not fairly set in; nor is it certain as to the exact nature of the conditions of the pregnancy. For all practical purposes the rule I have just laid down is absolute. Let us examine the symptoms, and follow them to the fatal result.

After a patient has been in hard labour for some time she perspires profusely, her face becomes congested, the pulse becomes rather quicker, the tongue furred; she becomes restless, anxious, perhaps light-headed; the urine is scanty, and the vaginal secretions are lessened. Should she be delivered at this stage, these symptoms quickly subside, and no harm is experienced; but if she continue in labour, the pulse gradually rises to about 100 per minute, the skin gets dry, the countenance becomes more anxious and haggard, the tongue brown and dry, there is much thirst and the lips parched, the passages hot, tender, and swollen, and perhaps dark; the uterus, acting violently at first, becomes tender on pressure, and the pains more distressing, while they are frequently short and flashing. The uterus, however, is by no means inert, for while the rhythmical action is becoming less in its duration, a continuous action is being substituted; so that instead of the uterus being flaccid between each pain, it is hard and firm—in other words, contracted. This condition of the uterus it is very important to recognise, because it is most probably the cause of the serious symptoms which attend unrelieved labour—at any rate, they appear coincidently; and also because the action in itself is a cause of detention of the fœtus, the uterus grasping rather than extruding it. Again, the fœtal life begins then to be in serious jeopardy, from the continuous pressure perhaps on its funis. Certainly there is a limitation of its blood-supply by the permanent diminution of the calibre of the blood-vessels of the uterus, and retardation of the circulation in the placenta, which, if not producing absolutely the death of the fœtus, yet acts very deterioratingly on it. Leaving, however, this point for a moment, I will continue the narration of the symptoms which pass on to what has been misnamed "powerless labour." Gradually, as this state of continuous action becomes more and more established, so you will find the rhythmical pains diminished, till the one is substituted for the other; the fœtus decomposes, frequently gas of a most putrid odour escaping from the uterus, the fœtus sometimes becoming largely distended by gas—thus increasing the difficulty of delivery; the patient's face becomes pale, with a sardonic grin, the tongue is dry and brown, the pulse rapid (130 to 160 per minute) and often intermitting; and when there is loss of voice, delirium, cold extremities, gasping, passing fæces involuntarily, jactitation of limbs, death is not far distant. If the patient be delivered before these latter symptoms arise, she may recover, but it is seldom that she does so after. Should she survive labour a few days where the child has decomposed, the system is often so infected by the putrid elements that the odour is evolved from the body some days after labour. If she do recover after these protracted labours, she may do so only to show serious lesions: she may have severe effusions round the uterus, as parametritis, perimetritis; cystitis; vesico-, or recto-vaginal fistula; and pelvic abscesses.

Let me now again revert to the continuous action to which I have above alluded. The diagnosis is not difficult. If it be present, then the uterus, if the waters have escaped, is firmly contracted round the fœtus. It assumes more or less its shape, and percussion about the outline of the uterus shows the resonance to cease abruptly and distinctly; whereas, if it be relaxed, there is dulness beyond the outline of the fœtus. Again, if the uterus be contracted, it is more or less fixed as it were against the brim, and the fœtus cannot be moved about freely; but if the uterus be relaxed, the fœtus is readily movable, and outside of it there is an undefined outline of the flaccid uterus. This is more apparent if the membranes be perfect; but, supposing the permanently contracted state were to occur before the rupture of the membranes—which is rare,—then of course the uterus would not assume the fœtal form, but its rigidity

would prevent our feeling it plainly. Now, I have never seen a case where, while the uterus became relaxed during the interval, the pulse began to rise and the other symptoms came on, except in the rare instances of rupture, or where there was some other disease coincident with labour; and the existence of these are not difficult to recognise, because in cases of coincident disease, we find the symptoms either before or early in labour, and in case of rupture there are general symptoms sufficiently marked, as I shall by-and-by point out. When the uterus has once fairly acquired this irritable state, the fœtus is seldom born by natural means, though, in a few cases, by the administration of moderate doses of opium repeated at short intervals, we may so far bring back the uterus to a healthy action as that it may expel the fœtus, or by the inhalation of chloroform the same result may be produced. And, although it is proper first to employ these methods, yet, if we find them fail, the indication is clearly to employ traction for the delivery; and we must be careful not to wait too long expecting these remedies to act, as thereby we may allow the constant contraction to be more intense. When I say that traction is the action distinctly suggested, it is just possible that delivery may be accomplished by gentle compression of the uterus by both hands towards the fundus. "Expressio fœtus," as it has been named, can only be of use in the early stages of this state.

Traction in general, therefore, is the action indicated, or the "pulling forth" of the child, as it used to be called; and when, after the application of the instrument, we attempt to draw down, we shall feel a resistance something like that of a spring (where the head is not detained by bony obstacle), for the uterus, grasping firmly the child, dips down into its inequalities, and thus a number of opposing projections occur to hinder the descent of the fœtus. The uterus, therefore, is drawn down to a perceptible degree along with the fœtus, if the head be not impacted, as above mentioned, between bony obstacles. It is only when the attachments and supports of the uterus offer a greater obstacle to the descent of the fœtus than this grasping action that the fœtus is caused to press the uterine obstacle aside, and thus its descent is accomplished.

But we need not, in this class of cases, fear (as we do in feeble pains from inertia) to draw out the child, even although the rhythmical pain be but slight. When we have delivered the child, then the placenta is often in like manner held for a time—longer, generally, than in ordinary labour; and we have little apprehension, when it is expelled or even withdrawn by hand, that any flooding will occur—at least from a relaxed uterus. The contrary is the case when the fœtus is drawn forth from the uterus in the other condition—namely, with feeble pains and relaxed state between. In this event the uterus is very liable to relax after; and if the placenta be detached ever so slightly, relaxation means hæmorrhage. And then, when we (according to our rules) have removed the placenta, there may be an empty, uncontracted uterus, with its certain consequence, flooding. Yet some will answer that they have often employed the forceps in this half-acting uterus, and delivered without hæmorrhage. Certainly. But unless we find, as the head passes the perinæum, that the pains are roused, we ought never to reckon upon immunity from flooding. We ought, then, if we *must* deliver in this condition, to be slow in our traction, and not proceed unless the pains fairly respond, which we should also endeavour to excite by secale and other uterine stimulants.

(*To be continued.*)

SATURNINE GOUT.

(Under the care of Dr. S. Wilks.)

A young man, aged 29, had worked since he was a lad in an oil-cloth factory, and had had much to do with white lead. On two occasions, he had had colic, but rapidly recovered under treatment. For some weeks he had not felt well, being weak, and having flying pains about him; but he had continued his work until a few days before admission, when his present colicky symptoms appeared, which, increasing in severity, obliged him to come to the hospital.

On admission, his principal symptom was colic. He was a spare, pale young man, with a well-marked blue line on the gums; his left foot was painful, from inflammation of the ball of the great toe, which exactly resembled gout. The urine was slightly albuminous, and the radial artery was somewhat hard. He was first ordered opium, and afterwards croton oil; and, when free of the colic, iodide of potassium.

Clinical Remarks by Dr. Wilks.—You may observe here two sets of symptoms; those directly due to the poisonous effects of the lead, and those due to the gout induced by the lead. There are apparently, therefore, two different classes of symptoms due to lead, the direct and the indirect.

The symptoms due directly to lead are especially seen in the anæmia and atrophy, which persons long subject to its influence so markedly show. The atrophy may be due to the same action long continued, of which we make use beneficially in arresting hæmorrhage, and to the power which this metal exerts, through the nervous system, in contracting the arterioles, and so stopping the flow of blood. At all events, those who are poisoned by lead soon begin to waste away, and their muscles become smaller and smaller, until they are unable to stand, or raise their hands to their heads! This wasting of the muscles exactly resembles what is seen in the idiopathic progressive muscular atrophy, and, what is very remarkable, is amenable to remedies. The most extreme cases of muscular atrophy of this kind which I have seen have been cured, and more especially by galvanism; the continuous current being the most beneficial, as faradisation has very little influence over the wasted muscle. When a patient has muscular atrophy, dropped wrist, or colic, your suspicions of lead-poisoning are aroused; but I would have you to remember, that persons who are working continuously in lead, or grinding it, often suffer more rapidly and acutely from the metal; though, as no symptoms exist, you might overlook the cause. An example of the kind was lately under our notice in Mary Ward. A young woman had been working for some months in a lead-factory, when, becoming weaker and weaker, she was obliged to desist. When she came to the hospital, she was seen to have a pale waxy appearance, and was very thin. She complained only of debility. On mentioning her occupation, a blue line was found on the gums. We believed, therefore, that she was suffering from plumbism; we gave her iodide of potassium and nourishing diet, and she slowly regained her strength. Besides the anæmia and muscular atrophy, if the poisonous effects still continue, the nervous centres become affected, and the patient becomes generally paralysed and demented, or may have convulsions.

As regards the blue line, it is true that it is more marked on an inflamed gum around a decayed tooth, but in this case the line was well marked on a perfect set of teeth. It may be distinguished from the discoloration caused by carbon or other pigments, by the dotted appearance when seen under a

lers. It is also said that when the lead circulates afresh in course of elimination by means of the iodide, that the patient may again have colic; this I have not noticed, but I have seen the blue line on the gums become much more marked under treatment.

One of the most interesting facts, however, in connection with lead-poisoning, is the production of gout, and apparently true gout; since the arthritic inflammation is due to the deposit of urate of soda in the joints. I have seen this gouty condition so very often, that I have no hesitation in confirming the statement of Garrod and others, by whom the remarkable connection was first observed; for, in several of my cases, the patients were young, and the ordinary predisposing and exciting causes were not present. I believe the observation is comparatively recent, for the great authority on lead, Tanquerel des Plaches, does not refer to it. It is true, that he has a chapter on saturnine arthralgia; but he evidently does not refer to the joints, but to the limbs, as his equivalent expression is "douleurs neuralgiques des membres," referring to nerve-symptoms, which, I may tell you, were known to the Greeks as one of the effects of lead.

It is remarkable, too, that not only is genuine gouty inflammation of the joints caused by lead, but of necessity all the other usual concomitants of gout. Therefore, it is constantly observed that workers in lead not only have chalky joints, but have granular kidney, thickened blood-vessels, and the other changes constantly met with in gout, and which are almost synonymous with those of Bright's disease. In the present case the urine was slightly albuminous, and the arteries slightly rigid and tense, suggesting the early condition of the change which I name.

This connection of lead and gout is so remarkable, that we naturally try to discover where it lies. We must first ask ourselves what we mean by gout. We generally mean by it, that morbid condition of the system which is due to the production of an excess of urate of soda, owing to a malasimilation of food. Now, this may occur under various circumstances from different causes; as, for example, the taking of too much nitrogenous food or wines, which directly favour its production; or, in other cases, from want of exercise, and consequent failure to get rid of the effete material; and, in other cases to simply atony of the stomach in nervous and weakly subjects. The question, therefore, which we have to ask is, in what way lead-poisoning so affects the digestive and assimilative processes as to favour the production of this salt. This, we believe, is the question to be asked, and not a simple chemical one, because we find attacks of gout caused by disturbances of the nervous system, and relieved by such remedies as quinine, mineral acids, and colchicum; causes and remedies which can only indirectly affect the functions before named, and do not act by simple chemical methods. When we think we can solve difficult questions in pathology and theraputics by known laws, let us ask ourselves how lead causes gout, and how colchicum cures it.—*British Medical Journal.*

APPOINTMENTS.—Douglas William Duke, L.R.C.P., M.R.C.S., assistant-surgeon to the East Sussex, Hastings, and St. Leonards Infirmary. Also Edmund O. Day, M.R.C.S., resident medical officer to the Royal Infirmary for Children and Women, Waterloo Bridge Road.

THE Duke of Rutland, who has been seriously ill, is now much better. He has had the advantage of being attended by an old Guy's man, Mr. Shipman of Grantham.

THE WILL OF THE LATE BARON MAYER DE ROTHSCHILD.

The will of the late Baron Mayer Amschel de Rothschild was proved at the Principal Registry of her Majesty's Court of Probate on the 2nd instant. The personal estate and effects of the estate of the said deceased were sworn under the enormous sum of £2,100,000, the probate duty stamp amounted to £31,500, and the miscellaneous fees (namely for depositing the document for proof, &c.) exceeded £95. The real estate is never included in the probate, therefore the exact amount of property a person may leave to be inherited by others cannot always be ascertained. The deceased is described in the will as of Mentmore in the county of Buckingham, and of 107, Piccadilly, in the county of Middlesex. The Baron represented the Borough of Hythe in the House of Commons from the year 1859 until the dissolution of the last Parliament.

SAMARITAN FUND.

The following is an account of the amounts collected from the Samaritan Fund in the boxes in the wards, &c., on the 31st December, 1874:—Accident, £1 3s 8½d; Cornelius, 17s 0½d; Lazarus, £1 2s 9d; Job, 5s 5½d; Luke, 5s 3½d; Naaman, 14s 6½d; Samaritan, 11s 3¾d; Patience, 1s 7d; Charity, 3½d; Dorcas, 11s 0½d; Martha, 9s; Lydia, 19s 0¾d; Eye Wards, 13s 6d; Philip, 2s 5½d; Stephen, 1s 3¾d; Mary, 11¾d; Addison, £3 8s. 6¾d; Clinical, £1 7s 9d; Bright, 2s 7d; Out-patients' Rooms, £1 1s 9½d; Lodge, £2 2s 6¾d; Front Gate, £1 14s 3d; total, £17 16s 8½d.

THE HOSPITAL SUNDAY FUND.

A public meeting in connection with this fund was held at the Mansion House on Monday last, when Sir Sidney Waterlow, in the absence of the Lord Mayor, occupied the chair. The Chief Rabbi, Archbishop Manning, and several distinguished representatives of the Established Church were present. It was resolved that the 13th of June should be fixed as Hospital Sunday for 1875.

THE PHYSICAL SOCIETY.

The seventh meeting of this Society will be held to-night, in the Chemical Theatre, when Mr. H. S. Branfoot will be in the chair, and Mr. J. M. Hobson will read a paper on "The Morbid sounds of the Heart."

WE note from the Journals, that Drs. Michael Forster and F. M. Balfour have written a work upon Embryology. To those who are intending to compete for honours at the first M.B. at London this work will be very valuable. The authors intend to write a work which shall give a comprehensive account of the developmental phenomena of the animal kingdom, and this is the first instalment. It contains a very detailed exposition of the structure of the embryo of the common fowl, from its earliest to its latest stages, and hence will furnish, in as complete and yet concise a manner as possible, all that will be required from candidates on that subject, while the accounts of the views of other embryologists which it contains will aid in giving a general view of the subject. It is also designed to be a practical guide to any who wish to make embryology a study, but the authors forewarn any such that there are two requisites to this, viz., a practically unlimited supply of eggs at any desired stage of development, and time free from all other engagements.

In Memoriam.

JOHN HENRY VINTER.

Death is busy, very busy, among Guy's men now. Within the last month have been recorded the deaths of two of those who were but a short time since with us; and now, at the opening of the New Year, it is our painful task to add one more to those have gone before—we mean John Henry Vinter.

It seems hardly a day since we were with him, and grasped him by the hand that is now for ever cold. Removed so suddenly from among us, we scarce can comprehend that his kindly face, that was so well known, will be seen by us no more. Known principally as he was among senior men, yet we doubt not he has left behind him many friends among his juniors, who will, with us, deeply feel his loss.

He had been suffering for some time from chest symptoms, and last year was laid up with pneumonia, and again in May with double pleurisy when he was brought very low. He rallied, but did not take that rest and change he required, and when he did those of his friends who knew him best saw too plainly the difference in himself that disease had caused. His lungs were never at any time strong, and though to all appearance he took care of himself, he had another attack of pneumonia (?) in the middle of December last, he still struggled on buoyed up with hope and youth until the New Year, when hæmoptysis set in from which he gradually sank. Stricken down in the beginning of manhood, when his work here was nearly accomplished, and he was looking joyously forward to the spring, when the goal he had so long hoped for would be attained—his loss seems doubly great.

He was kindly and assiduously attended during his illness by Dr. Moxon, in conjunction with a medical friend.

To those he has left behind in the hour of their grief we would humbly tender our heartfelt condolence. Though absent in the body, his memory, which is printed firmly on some of our hearts, will long be present.

DEATH OF A HOSPITAL SERVANT.

It is with sincere regret that we record the death of Edward Hunt, at the early age of thirty-two, which took place somewhat suddenly on Friday, January 1st. It is unnecessary for us to chronicle the history of his life, for he was equally well known to all connected with the hospital—known as a thoroughly trustworthy, cheerful, and popular servant of the institution, who will be missed, as much on account of his genial temper as his valuable services.

The conditions which led to his death are, in a medical point of view, of some considerable interest. During the greater part of December he had been laid up with a sore throat, of which he was just becoming convalescent, when an attack of acute rheumatism set in. This had lasted about a week, and he appeared to be doing very well under Mr. Stocker's care. He had sweated very freely, but the pain had never remained stationary in the same joint for more than a day. On Thursday morning (Dec. 31) the sweating ceased at out eleven o'clock, and in the afternoon the pain in the joints completely disappeared, he expressed himself as much better, and turned over on his side. In the evening he became delirious and subsequently comatose, and the House Surgeon, Mr. Chicken, was sent for in a hurry. Mr. Chicken found upon his arrival that the temperature in the axilla was 108·8 deg., and called in Dr. Taylor, who recommended the cold bath. However, an hour elapsed before the bath and water could be procured, by which time the temperature had risen to 110·9 deg. He was placed in the bath at 90 deg. and kept in it for 35 minutes, during which time it was gradually cooled down to 66 deg. At the end of eight minutes the thermometer in the rectum registered 111·2. From this time till the end of the 35 minutes it gradually fell to 106·6; but he remained quite unconscious, the pupils being contracted. Half an hour after the bath the temperature had fallen to 101·3 deg., and an hour after to 99·3 deg. (still in the rectum). Two hours after the bath it showed signs of rising, and was in the axilla 100 deg.; but though taken occasionally almost up till the time of his death, it never attained 103 deg. in the axilla. The pupils became widely dilated.

The great points of interest are those which we have noticed in all similar cases—the pain in the joints and sweating ceased, and the temperature fell very much after the bath. Cases where the temperature has not been quite so high have always become conscious after the bath, therefore we can suppose that the great heat must have led to some distinctive change in the delicate tissue of the brain.

We have, however, besides medical interest another point of view to which we wish to direct the charitable interest of our readers. Hunt, a strong, healthy man, has been suddenly cut off in the prime of life, and we are not surprised to find that he has left a widow and child unprovided for. We recommend them to your liberality. A subscription list may be seen in the office, the Library, or the "Rooms," and we have confidence that our recommendation will be supported, not because we are dealing with an immense annual income, but rather with purses for the most part very slender, but governed by kind hearts.

Operations.

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On Tuesday, Jan. 5th, the following operations were performed:—

Mr. Birkett removed an epulis from the lower jaw of an old man. It was attached by a narrow pedicle, which was cut through with a pair of scissors, and then the remainder of the growth was scooped away from the bone. The facial artery, on the side which was operated on, was enlarged, and there was considerable hæmorrhage. No chloroform was administered.

Mr. Birkett then applied the hot iron to a tongue, from which an epithelioma had been removed some time ago, and in which a small point of hardness had made its appearance.

The hot iron was also applied by Mr. Forster to the face and nose of a girl affected with lupus. This treatment had already been effectual in removing the greater part of the disease.

Two cases of epithelioma of the lower lip—one of six years' standing, and the other of six months'—were next operated on by Mr. J. C. Richards. The usual V incisions were made, and the margins of the wound brought together by sutures.

Mr. Durham then applied a ligature to a case of fistula.

Reports of Cases.

An interesting case of ague came to the out-patient room lately, showing how this affection varies in different climates.

J. G., æt 21, was in America from January to March of the past year. During this period he had four attacks of intermittent fever, each attack lasting three days, and recurring every three weeks. On the first day he was feverish, on the second he shivered, and on the third he was still hotter than on the first, the fourth day he was well. Early in April he sailed for England, a day or two after a paroxysm, and landed at Liverpool on the fourteenth day. Two days subsequently, he "caught cold," and tertian ague attacked him. The paroxysms now lasted but eight or ten hours, and he passed through the cold, hot, and sweating stages in the usual order, and not, as in America, a shivering stage. After a few weeks he came to Guy's as an out-patient, and quinine soon cured him. He is now again attending for tertian ague.

FRACTURED SPINE—EXTRAVASATION OF URINE.

J. H., æt. 9, fractured his spine in the lumbar region on Nov. 6th, 1874, and was admitted next day into Cornelius Ward, under Mr. Cooper Forster.

On admission, there was loss of motion and sensation in his legs, the anæsthesia extending upwards to just above Poupart's ligament. Above this there was hyperæsthesia. Urine was retained and required catheterism, whilst the fæces were passed involuntarily.

On passing a catheter, there was a slight constriction about three inches down the urethra. For about nine days catheterism was continued three times daily, for the relief of the retention, which then passed into a state of incontinence. After this, there being no distention of the bladder, catheterism was accordingly discontinued for a time.

On the 20th of November retention again occurred, and a catheter was passed. This time, it was found that urine flowed, and the bladder could be completely emptied as soon as the catheter had been passed to within about two inches of the neck of the bladder. It easily passed beyond this point, but the flow of urine stopped again, and then the further passage of the catheter was obstructed.

On the 22nd, the scrotum appeared œdematous, and next day was distended with fluid, while over the pubes and extending a short way up the abdominal wall was a swelling evidently due to extravasated urine. Incisions were made into the perinæum and scrotum to give egress to the fluid. There was now incontinence of urine again, and none flowed when a catheter was passed. The urine had been very dark, thick and fœtid.

On the 25th, the urine appeared through the wound in the perinæum and gangrene appeared at some of the incisions in the scrotum, while extravasation continued to extend beneath the faciæ of the abdomen, and a point of gangrene appeared over the middle of Poupart's ligament. There was also a tendency to gangrene in the feet. The boy lingered till the 27th, when he died at 2·50 a.m.

At the autopsy, it was found that there had been a very intense inflammation of the bladder, the walls of which were sloughing; the urethra had become converted into a large abscess from the base of the penis to the neck of the bladder, while the inflammatory process had extended up the ureters into the kidneys, which were suppurating. There was also broncho-pneumonia of one lung. The fracture proved to be at the first lumbar vertebra.

This case is interesting, on account of the very intense inflammation which had occurred in the whole of the urinary tract, whereby an abscess-sac was formed in place of the urethra, into which the catheter passed, and from which the bladder could be emptied. The extremely low vitality of the paralysed parts was well shown by the tendency to gangrene in the feet.

Obstetrics.

UTERINE FIBROID POLYPUS—EMBOLISM—HEMIPLEGIA.

J. S., was admitted into Mary Ward, on the 3rd Nov., suffering from metrorrhagia for eighteen months. Single, living in a family as cook. Vaginal orifice was so contracted, that Dr. Hicks was unable to make a proper examination till the patient was under chloroform, when, with great difficulty, he dilated the parts sufficiently to feel a polypus projecting through the os. On three occasions, the largest of Barnes' bags was introduced, so that its central constriction was opposite the vaginal orifice, and then distended with water, a T bandage being applied to keep it *in situ*, but it caused so much pain that it had to be removed in a few hours, and effected very little stretching. Ergot was given, both in powder and the liquid form, but caused sickness, indeed the patient could retain neither food nor medicine (with the exception of the gallic acid mixture) after the 20th Nov.

On the 23rd, the patient was much worse, pulse 132, thready, temp. 101, resp. 34; two days later the left leg became swollen, but no hardness of the vein could be felt.

On the 24th, she suddenly became unconscious, and the left side was found to be paralysed. Consciousness only partially returned, and she died on the following day.

P.M.—Brain, an ante-mortem clot was found in the right carotid artery, which extended into the middle cerebral. This region of the brain was much softened, being easily washed away under a stream of water of small force.

Lungs slightly emphysematous. The pulmonary arteries on both sides plugged with ante-mortem clots.

Heart—On the right side were six or eight ante-mortem coagula, projecting from the sacculations between the various muscular trabeculæ. The left side was normal.

Veins—Those of the œdematous leg were free of ante-mortem clot.

Uterus.—The anterior lip was replaced by a tough, yellowish, fibrous tumour, about three inches in diameter. It grew from the inner surface of the cervix, and, having dilated this, was now dragging upon the body of the uterus and tending towards an inversion. The polypus was pedunculated, but the pedicle was broad. A small sub-peritoneal fibroid grew from the posterior surface of the uterus.

The embolism of the brain was accounted for, by supposing that the swollen left leg was caused by thrombus of

the saphena or femoral vein, whence clotting in the right heart and pulmonary arteries was started, the latter led to some plugging in the pulmonary veins, and here arose the embolus which plugged the carotid artery.

The Dissecting-room.

Neither first year's men, nor those of us who are working for the First College, will be able to complain that they were unable to obtain a sufficient number of "parts" during the present session. In our last notice we mentioned that twelve subjects were lying ready for gentlemen on their return from the country. Two more came to us on Monday, so that the half-session commenced with a store of fourteen subjects. Since Tuesday four other subjects have been received, raising the number delivered this session to sixty-two. As during the whole of the last academical year—from October, 1863, to October, 1864—only eighty-four subjects were received, it may be judged how great an increase in the supply there has been this year.

The Wards.

MEDICAL.

The following Cases were admitted between Dec. 30 and Jan. 6:—

ADDISON.—8—Bronchitis. 23—Eczema. 26—Phthisis. 28—Chorea. 30—Chronic rheumatism. 32—Rheumatic fever.

MARY.—No admissions.

STEPHEN—5—Morbus cordis—præsystolic. 9—Chorea. 10—Phthisis. 12—Phthisis. 15—Empysema. 18—Rheumatic fever.

JOHN—2—Enterica. 7—Morbus cordis. 8—Phthisis.

MIRIAM.—19—Bright's disease. 22—Pleurisy. 28—Cardiac disease. 29—Phthisis.

SURGICAL.

The following cases were admitted between Dec. 30 and Jan. 6:—

LUKE.—3—Cleft palate of lower lip. 4—Epithelioma. 5—Wound of knee-joint—amputation. 12—Tumour of upper jaw. 15—Vesical calculus. 18—Fractured fibula. 10—Synovitis. 20—Epithelioma of lip.

LYDIA.—No admissions.

CHARITY—7—Double fracture of leg, and fracture of humerus. 13—Hæmaturia after abdominal injury. 15—Cut throat.

MARTHA—No admissions.

NAAMAN.—16—Ruptured intestine.

DORCAS—No admissions.

CORNELIUS.—6—Compound fracture of fore-arm—amputation. 7—Fractured tibia and fibula. 15—Fractured tibia and fibula. 15—Fracture of fibula. 16—Fractured base—trephining. 17—Fractured ribs. 18—Fractured tibia and fibula. 19—Fractured tibia and fibula.

JOB.—No admissions.

ASTLEY COOPER—7—Fractured spine. 12—Synovitis. 18—Hydrocele.

DEATHS.

On December 30th, William, fourth son of Thomas Le F. Greaves, Esq., of Great Easton, Leicestershire.

On the 4th inst., at Walton-on-Thames, J. H. Vinter, Esq., a fifth year's student, of phthisis.

DEATHS IN LONDON FROM THE COLD WEATHER.—The Registrar-General states that it was well established by the researches of Villermé and Edwards, that young children die in considerable proportions by exposure to cold, and it was known in a general way that the winter is more fatal to old people than to young. The weekly tables carry us much further, and show that the mortality after twenty increases with age rapidly, and that after a determined law. Thus, if we divide life into vicennal stages, then beginning at twenty, forty, sixty, and eighty, the result in London in the six weeks of very cold weather, ending Feb. 24, 1855, was found to be that the mortality due to cold, at the four stages, was 2·0, 7·5, 44·9, 181·8; so rapidly did the power of resistance decline with age. Taking the increase of mortality by cold between twenty and forty as one, then the mortality became two, four, eight, and so on, "doubling every nine years." The effects of the cold of the five weeks that ended on December 19th, have been tested in the same way, by comparing the deaths at each age with the deaths on the five previous average weeks. The deaths were raised from 6,967 to 9,871, so the excess due to cold was 2,904 in the five weeks, and on an average 581 weekly. The mortality, higher than before, increased with age at the same rate; it was in every 1,000 living at the four ages, 2·2 at twenty to forty; 9·4 at forty to sixty; 46·9 at sixty to eighty; and 218·3 at eighty and upwards. The mortality from cold increased eight per cent. for every year of age; or it doubled every nine years from the age of twenty, as it did in 1855. Thus there is a law of mortality from excess of cold. But it must not, therefore, be assumed that the mortality is beyond control. The air we inhale at 28 degrees or lower, is raised not to blood-heat, but to something approaching 98 degrees when it is exhaled; and as about a gallon of air is thus heated every minute, and as the evaporated vapour in the breath also carries off a considerable quantity of heat, the loss by the lungs is large however warm the clothing may be. The cold is most effectively combatted by exercise, which excites the heating energy of the system; and warmth is sustained by nutritious food; by artificial heat; by warm woollen or fur clothing; and by the respirator, which retains the heat exhaled by respiration. The aged poor in the cold season of pressure require all these helps, and have claims not only upon their kindred, but upon their wealthier brethren.—*British Medical Journal.*

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Guy's Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—No. 15. SATURDAY, JANUARY 16, 1875. TWOPENCE.

We beg to remind our readers that subscriptions for the ensuing three months are now due, and will be received by either of the Presidents of the Physical Society.

THE necessary curriculum for the College comprises four winter and three summer sessions, and then, our examinations being over, we are considered eligible for practice, and the happy, free, and sunny life of a hospital student ceases. In the majority of cases this rule holds good, and the new doctor leaves the hospital, buoyed with hope of future success, and confident in his skill. Poor fellow! to what is he doomed? A few, very few, have a lucrative practice and a circle of friends awaiting them; but, by far the larger number soon learn the drudgery of assistantship or experience the loneliness of a country hospital, and look sadly back to the dear old *Alma mater*. Entering at a London hospital, the first year's man feels strange and not in his element; but soon he makes a friend or two, and, getting into the full swing of work, enjoys the change from school life to freedom of thought and action. Lectures, dissecting, and reading make time pass happily, and the First College is soon come. This over, we consider the full enjoyment of student life begins. Every man, who has made up his mind to be a doctor, must love Medicine and Surgery, and enjoy its study; whether this be by reading and hearing lectures on the theory, or by bedside practice. The latter, in our opinion, is the pleasantest, and, at the same time, the most profitable way of spending the time. It is our proud boast, that the wards of Guy's Hospital are open at all times and to every student; and they afford ample means of becoming practically acquainted with the various phenonema of disease, and the different measures adopted for its arrest. Living, as we are, in the enjoyment of such advantages, we have reason to be content; but the day will come, when, like our predecessors, we shall be drifted out into the world to fight for ourselves.

It is said a Guy's man can always be recognised, "they are so much more practical than those from other schools." We hope this is the case, for it is only another way of saying that they are better professional men.

A STUDENT'S NOTES OF

Lectures on Midwifery.

—o—

By J. BRAXTON HICKS, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

LECTURE X. (*continued.*)

Thus, you see, we have two states, both with feeble pains—one with the uterus contracted between, the other with a relaxed uterus. In the former we *must*, in most cases, use traction, and this we can do with safety; in the latter we *may* use the forceps in special cases, but not as a general rule, and always in fear and with much caution. Now, I said before that sooner or later serious symptoms arise if labour be not relieved, in whatever position the detention may arise, and whatever the presentation. Let us consider this further. You will remember that I told you of natural labour: that the pains altered as the head descended out of the uterus; and that the lower it came down the more forcing became the pains, till they reached their maximum at the outlet. I pointed out to you the great force the uterus exerted, and the power of the auxiliary forces. The exercise of this function demands a copious generation of nerve-force. The demand, therefore, necessarily increases

as labour advances, because a larger area of reflex irritation exists when the head is partly in the cavity than whilst in utero, and again a still larger when it is at the vulva. If the constitutional symptoms indicative of detention are mainly dependent upon this enormous demand upon the system, then it is easy to understand why the lower down the fœtus is the sooner untoward symptoms are in arriving; and yet it has been the remark of most authors that it was difficult to explain this clinical fact. Some have explained it by the bruising and contusion to which the soft parts are subjected. Doubtless this has an important influence, but by no means the whole; because it is readily to be noticed, that unless the case has proceeded to the more serious kind of symptoms, they vanish very rapidly after the delivery of the child—in a few hours, often sooner. Whatever be the explanation, you will find this clinical fact plain enough: that the lower the head is down, the sooner will untoward symptoms appear.

Again, with regard to the presentation, you will observe this other clinical fact: that the larger and harder the presenting portion of the fœtus, the quicker will arise dangerous symptoms. We may take the fœtal head as the maximum of hardness, and the foot as the minimum of size; and you will observe that while untoward symptoms appear early in head presentations, so when the foot or hand present they are slow. So slowly, so insidiously do they come on in these presentations, that they notably form the most dangerous traps for young or ignorant practitioners.

But to assist you in being alive to this danger you must bear in mind the difference in the "pains" in the several stages of labour. If, while the fœtus was wholly held in the uterus—for instance, by a rigid os,—you were to wait for the arrival of forcing pains before you thought it proper to assist, you would be waiting for that which will never arrive, whilst slowly, but surely, the patient drifts on to danger. Often have I seen this mistake made, and not always by a student. I have seen a woman in a most perilous state from this expectation; I have seen utero-vesical fistulæ result from the same in two cases, and yet the pulse had been at 130 to 150 per minute, without the attendant suspecting danger. Recollect, then, what I have before told you respecting the character of the pains in the various stages of labour.

You must also take into account the temperament of the patient, and her general state of health at the time of delivery; and although no definite guides can be laid down, yet we may be sure, if the temperament be extremely excitable, or languid, and her general condition depressed by previous illness, anxiety, or exposure to unhealthy influences, whether in high or low station of life, that there will be but a limited tolerance of detention of labour.

I may give you also these general rules as your guide:—

1. If the obstacle does not appear insuperable to nature, then you may fairly wait to see whether natural powers are sufficient. If, however, untoward symptoms supervene, you must not wait longer, but interfere.

2. If you are certain from the first that the obstacle is insuperable by nature, then do not wait longer than is necessary for the fair establishment of labour; I mean, in those cases where it is not determined to deliver otherwise than *per vias naturales*, do not wait till the patient is irretrievably damaged, the child dead, or the chances of recovery for the mother lost.

Hence another simple rule follows.

3. Examine every patient as early as possible in labour, to ascertain if any and what kind of impediment exist.

But although I have just given you the guides as to when you *must* draw the child from the mother, yet it is very difficult to give you a precise idea as to when you *may* draw it forth without injury to her. Because, while it is admitted that very long labours are detrimental to both mother and child, yet it cannot be altogether admitted that a fairly long labour in a strong woman is detrimental. By long action of the uterus the organ is made highly sensitive to reflex action, and its persistent contraction is thereby secured after labour is over, and thus hæmorrhage rendered less likely, and retention of discharges prevented, and toxæmia from the absorption of their decomposition.

There is doubtless a broad range for option in the rendering of assistance; and much discussion has arisen as to the extent of this ground—some employing assistance very early in the case, others giving help very sparingly. I think a medium plan will be found the best, both clinically and politically, at least for beginners.

When I come to the description of each kind of obstacle to labour, you will be good enough to remember these observations, which will not require to be reiterated upon each occasion. Their application can be readily applied by you.

After these general remarks upon obstructed labour, I will pass on to remark upon the effects upon the child of hard and prolonged labour. I might state this as a clearly recognised fact—that the longer the labour, the more danger for the child. I am not aware of any facts which point out that there is any advantage to the child in the process of labour. Every one agrees as to the possibility of danger to it. The only point is, how long may labour exist before actual danger arises? Before this question can be answered, we must understand the nature of the dangers. They arise principally from two sources—1, pressure on the circulation; and 2, pressure on the head.

Undue pressure on the blood-current may take place even in the uterus, when the uterus is in very frequent action or continuously so. So that when either of these two conditions are present, the life of the fœtus is in more or less danger. Undue pressure may also occur when the placenta is pressed between the fœtus and the frequently or continuously contracting uterus. The funis may be subjected also to pressure, if it be placed on some prominent part of the fœtal body. Again, if the placenta be inserted near the os, and particularly if the funis be near its lower margin, then the fœtal head in passing must press; the lower the placenta or funis, the more the risk to the child.

And the risk is not altogether dependent on the check to its nutriment and the aëration of its blood; it has been found that pressure on the funis will make the fœtus in utero to inspire. If this take place, its head being in utero, there is a great liability of its drawing into its lungs the secretions. This is found a not infrequent cause of still-birth; of course particularly liable to occur in pelvic presentations. This will explain the liabilities of secale to cause still-birth, if not given in well-selected cases. Secale is not poisonous of itself to the fœtus, but rather, by its tendency to produce over-action, it checks the circulation, and causes indrawing of secretions and deprivation of aëration and nourishment.

Regarding the pressure on the cranium, one might say that the more ossified the skull is, the less likely is the interior to suffer damage; while the more plastic it is, the more the interior suffers. The brain-tissue doubtless is damaged; but, besides this, the overlapping edges of the

bones sometimes penetrate the longitudinal sinus, and effusion of blood takes place, pressing on the brain. No doubt forceps can produce like results, but the uterine force alone is sufficient to do so, as I have myself seen, and even to fracture a thin skull against a prominent sacrum.

But the head will bear without damage a considerable duration of intermittent compression and of moulding, even though very severe, but it is impossible to fix the limits of toleration. For the mother, I think that the moulding of the shape of the head, especially in primiparæ, is an advantage to the subsequent employment of the forceps, which never can produce such general reduction of the diameter as can the forces of nature. So that if we deliver by forceps before this is fairly accomplished, we shall have to employ more severe traction than otherwise. Besides the immediately fatal effect of pressure on the brain of the fœtus, there is no doubt considerable damage done, which, though not resulting in death, yet in course of time shows itself in diseases of the nervous system; and it has been said that even for a year or a year and a half, after-symptoms, such as tonic contraction of the limbs, may arise, traceable to the effect of pressure in the birth, either by nature's efforts or by the forceps.

Again, long-continued pressure may produce on the scalp sloughing over the parietal eminences, as I have myself seen, or a caput succedaneum accompanied by effusion of blood, or, as it is called, a "cephalo-hæmatoma." This latter, however, though seldom serious, may be attended by suppuration, and for a long time by thickening.

It is impossible to give you any clear statistics of the untoward effects of prolonged labour on the child, but perhaps the cases reported by Dr. Collins, of the Dublin Lying-in Hospital, may be taken as a guide. Of 324 patients delivered naturally over twenty-four hours, sixty-one were dead, or about one in five.

In more protracted labours the death-rate is of course much greater, and it may be said to increase in a geometrical ratio.

Operations.

On Tuesday, Jan. 12th, the following operations were performed:—

Mr. Bryant excised a knee-joint in the case of a boy who has dislocation backwards of both tibiæ as a result of suppuration. A few weeks ago, Mr. Bryant had divided the ham-string tendons, and the legs were put up on back-splints, but this was not successful in producing straight limbs, and the boy was again brought in with flexed legs. The left knee was therefore excised. A semilunar incision was made below the patella, which was then dissected out. Some union existed between it and the condyles of the femur. The synovial membrane was unhealthy throughout. The limb was put up in an iron splint.

Mr. Howse showed a case in which he had performed excision of the knee some time ago. The patient walked with only a very slight limp, the excised limb being but slightly shorter than the other.

The next case was one of extravasation of urine from impermeable stricture. A staff was passed down to the stricture, and then Mr. Bryant made a median incision in the perinæum through the skin and superficial fascia. Then by turning out the staff and feeling it with his finger, he cut down upon it and divided the whole of the diseased structures, also incising the portion of the urethra on the vesical side of the stricture.

Mr. Durham removed some carious bone from the os calcis. Only the outer shell of bone was left, nearly all the cancellous structure being diseased.

Mr. Howse then performed excision of the knee under the spray on a man who, some time ago, was under his care for effusion into the left knee-joint. This was tapped, and the man resumed his work. This involved hammering over the affected joint, and soon produced inflammation in the joint, which laid him up. He was repeatedly troubled in this way, and at last requested Mr. Howse to give him a straight ankylosed limb. The joint was found considerably diseased. The ligamentum mucosum was gone, and some portions of cartilage had become removed, while the synovial membrane was very unhealthy. The patella was removed. The limb was put up in an iron splint and paraffin dressing applied.

Correspondence.

To the Editors.

SIR,—I was glad to see your remarks in last week's *Gazette* on the importance of more attention being paid by students to treatment. Although the ancient conception of *curing* disease through the charm of drugs is becoming obsolete, and although drugs should only take their share in the contest with disease, yet that is no reason why each man, on equipping himself for the life-long battle, should not select some weapons which have appeared to him, as the result of a careful analysis, to be best suited for his purposes, and, at the same time, lay himself open to the attainment of better modes of warfare. I believe this condition of strength is to be acquired by taking careful notes—and placing them in groups according to diseases or symptoms—of the effects of drugs upon the economy. Take, for example, a series of cases of chronic tubular nephritis treated by all the physicians, and, with patience and careful analysis, a most valuable collection of facts relative to the treatment of so important a disorder would be acquired, a definite idea would be formed while the spirit of inquiry would be cultivated.

By such processes we should start on our course with the power, and not unlikely be stimulated in the desire to do much to help suffering humanity.

Yours truly,

ENTHUSIAST.

The Review of the "Catalogue of the Preparations of Comparative Anatomy in the Museum of Guy's Hospital," by Dr. Pye-Smith, speaks well of the volume. It not only specifies the specimens but it has prefixed to each class "a concise but clear account of its distinguishing characters," thus rendering the catalogue a manual of comparative anatomy for the student. The museum now contains 1,400 preparations in the vertebrate and 600 in the invertebrate division.—*Lancet.*

Physical Society.

At the eighth meeting of the society, on Saturday, the 9th inst., Mr. Hobson read a paper on "Morbid Sounds of the Heart," of which the following is an abstract:—

Mr. HOBSON commenced with some remarks on the Anatomy and Physiology of the Heart, and after referring to two or three theories as to the cause of the first sound, he mentioned the "fluid vein" of Savart, which consists of a jet of blood thrown into vibration by passing with velocity through a narrow aperture into the air, or a tranquil collection of fluid. These vibrations are perceived as a thrill and murmur only in the direction of the jet, unless a vein project backward from the constriction, when it is also heard in that direction. Two cases, recently in the hospital, were referred to as illustrating this condition. Button-hole mitral, ruptured chords, chords yielding with inversion of the edge of the valve, granular vegetations and ulcerations were then referred to. Dr. Fagge says that out of 67 cases of mitral disease, only twelve were not constricted. The cardiograph shows that the auricular contraction takes much longer than in health. The inference follows that the phenomena observed are due to a driving of a vibrating fluid vein through the constricted mitral, by the hypertrophied auricle. The evidences of aortic obstruction and regurgitation were next described, and it was suggested that the conduction of the regurgitant murmur, somewhat into the arteries was due to the inverted funnel of the aortic valves, whilst their vibrations being picked up by the sternum from the aorta as it approached that bone, might be an explanation, in part, of the loudness of the diastolic murmur down the sternum. A case was mentioned of a little girl in whom a bruit disappeared on two occasions under the influence of digitalis, strongly suggesting the idea of occasional leakage of the tricuspid. Mr. Hobson brought his paper to a close by mooting the question as to whether the prognosis was more favourable in mitral stenosis or regurgitant.

Mr. POLAND thought that some of the morbid sounds heard in front and not behind, might be due to pleurisy. The symptoms of heart disease more often occurred without a murmur than was generally supposed; therefore there were a great many more cases of heart disease than at present recognised. This might also in part be due to want of proper methods of auscultation.

Mr. PAUL did not think there was any necessity to be surprised at the number of cases of constricted mitral. Some were cases of congenital disease, while others were the result of subsequent contraction. Many cases of clinical systolic murmur were excluded from the post-mortem records. There was a great difference in the character of the murmur heard when the valve was only slightly contracted, and when it was markedly contracted. The diastolic murmur was heard down the sternum because it was probably conducted by the bone. The exact direction in which the murmur was best heard was said to depend upon which segment of the valve was diseased.

Mr. GREEN, in remarking on the fluid vein theory, reminded them that the left auricle contracted before the left ventricle, and by its contraction filled the ventricle. A murmur over the left ventricle, then, would be due to the blood passing into a chamber already filled with fluid. The question had been raised why digitalis sometimes caused a murmur to become less. As the effect of digitalis was to cause the heart to become more compact, was it not reasonable that valves which previously closed the orifice imperfectly would, after its use—as the heart contracted closer—close the opening more fully, and so prevent regurgitation.

Mr. FRY said that Mr. Hobson had only given two or three kinds of valvular disease, and had not described the sounds found in other conditions of the heart as dilatation, hypertrophy, &c. He had not spoken of musical or anæmic bruits. The former of these, Dr. Hughes taught, was due to tension of the chordæ tendinæ. In the only six cases which Dr. Hughes had seen post-mortem there was adherent pericardium associated with it; although this was probably a mere coincidence. Mr. Hobson had not spoken at all of congenital heart disease.

Mr. SYMONDS in speaking of murmurs that disappear, said they were often called "functional." The heart getting into an atonic condition, the valves, especially the mitral, would not act properly, they would not meet accurately, and so some blood would regurgitate. But on a good condition of the system being brought about, they regained their tonicity, were better able to adapt themselves to the orifice, and so the murmur might disappear. Mr. Hobson had told them of a case where by compressing an artery in the neck, and placing the stethoscope below, a murmur was audible. These were just the conditions present in constricted mitral, because there was probably never any loss of connection between the blood in the left auricle and ventricle. The blood was not sent into an empty cavity.

Mr. SHADWELL remarked that a morbid sound was sometimes present in a case of fibroid degeneration of the heart. What was it due to? In acute rheumatism he had often noticed an apex systolic bruit, which after a time disappeared. Was this due to inflammation of the endocardium, with consequent swelling of the membrane, the sound being lost when the swelling subsided, or was it due to a relaxed condition of the heart and alteration of the blood? Was the bruit in chlorotic girls due to altered blood? On pressing the stethoscope over the aorta a bruit was produced. This might give rise to a fallacy. Malignant disease, for example, of the mesenteric glands might transmit the impulse of the aorta, and on pressing with the stethoscope a bruit might be heard, and so lead to the suggestion of aneurism.

Mr. HETLEY was in the habit of regarding functional bruits mostly as uremic. They were almost always heard at the base, and generally over the seat of the pulmonary artery rather than the aorta. He had never heard a functional bruit over the apex, and had never yet heard an apex bruit which disappeared. The bruit over the aorta was caused by the stethoscope, functional bruits there were not at all common. Very little pressure would cause the sound, such as fæces in the colon. Musical bruits nearly always occurred at the base. They were frequently proved to have been due to a loose flap. Disease of the anterior segments of the aortic valves was more serious than disease of the posterior. They did not always get a præ-systolic bruit with contracted mitral, it might be systolic. The chief characteristic was the sharp delayed first sound.

Mr. E. DUKE alluded to a case in Mary Ward, which, on admission, was præ-systolic, then altered in character and became systolic, and was now again præ-systolic. Mr. Hobson had not mentioned the effect of Bright's disease on the sounds of the heart. In contracted kidney there is often re-duplication of the first sound.

Mr. LANCASTER thought the bruits heard in chorea were mostly functional. Some were perhaps due to endocarditis, but more commonly to irregular contraction of the musculi papillares. The cause of functional bruits was not clear. He could understand why an alteration in the blood should make a murmur, because—although the quality might be different—the quantity was the same.

After a few remarks from Mr. Elcum, a vote of thanks to Mr. Hobson was proposed by Mr. Harsant, and seconded by Mr. Hetley, and carried *nem. con.*

The meeting then adjourned.

THE EVELINA HOSPITAL.

WE understand that Dr. Frederick Taylor has been appointed physician to in-patients, in the place of Dr. Hilton Fagge, who has resigned. Dr. Goodhart has been chosen to fill the part of physician to out-patients, rendered vacant by the promotion of Dr. Taylor. Mr. Alfred Sangster has been appointed registrar to the hospital.

DURING the week we have received a most useful little Pharmacopœal Companion, price 6d. It consists of "A Posological Table of all the remedies of the British Pharmacopœia, arranged according to their Action," by Robert Bartley, M.B., Lond., Surgeon to the Bristol Eye Hospital. It is capitally arranged, and we would recommend each Guy's man, whether student or practitioner, to have one constantly in his pocket. We, however, cannot think that it (in the slightest degree) does away with the difficulties which were pointed out in our last week's article.

DR. E. KLEIN will deliver eight Lectures at the Brown Institute of the London University, on "Vertebrate Embryology," with demonstrations, from 2.30 to 4 p.m., commencing Saturday, January 30th. Gentlemen wishing to attend are requested to give their names to Dr. Pye-Smith. Fee, two guineas.

THE next meeting of the Physical Society will take place on Saturday next, when Mr. Waterhouse will read a paper on "Homœopathy."

MR. HENRY CLARKE, M.R.C.S., L.R.C.P. Lond., obtained the Diploma of the Apothecaries' Hall, on Thursday, the 7th inst.

Reports of Cases.

NECROSIS OF RIGHT TEMPORAL BONE IN A CHILD AGED THREE MONTHS—PYÆMIA—DEATH.

The mother has a strumous tendency, has lived well, and has plenty of milk. The child at birth was well nourished and healthy, and remained so until fourteen days before admission, when it was noticed to scream very much, and had convulsions; it also suffered from shortness of breath, and was said to have bronchitis; at the same time a swelling appeared behind the left ear, which seemed to be relieved by a discharge from the ear, which set in the next day. It improved until two days before admission, when its left arm began to swell, and soon after swellings were noticed on the right hand, and over the left sterno-clavicular articulation.

On admission (Dec. 31) the child is pale and wasted, passes green-coloured motions, and screams a good deal. The left arm is red and œdematous throughout, and shows signs of an abscess pointing above the internal condyle. There is an abscess on the back of the right hand, and another over the left sterno-clavicular articulation. The discharge from the ear is rather copious, and has the peculiar fœtid odour that usually occurs with pus from dead bone.

Jan 1st. It sleeps very little. Temperature 102·8, pulse about 200.

Jan. 2nd. Abscess on left arm burst. Morning, temp. 100·4, pulse 172. Evening, temperature 103, pulse 200.

Jan. 3rd. Dorsum of right foot and external genitals are swollen and red. Is taking cod-liver oil and steel wine, with ℥ 1½ port wine in water.

Jan. 4th. Sweats freely. Some paralysis of right facial noticed when it cries. Temperature at 10 a.m., 100: 2 p.m., 102·8; 5 p.m., 102.

Jan. 5th. Very restless last night. Morning, temperature 101·6, evening, 103. Some dysphagia.

Jan. 6th. Temperature 102.

Jan. 7th. Right facial paralysis more noticeable, vomiting. Morning, temperature 99·6; evening, temperature 100·6.

Jan. 8th. Vomiting ceased, cold sweats. Temperature 97·8.

Jan. 9th. Temperature 97, eyes sunken, evidently dying. In the early part of the evening had some starting of the limbs, but died quietly at 11 p.m.

Post-mortem. The right temporal bone was externally of a dirty yellow colour, bathed in pus, and separating from the surrounding bone, the tympanum was full of pus, and the petrous bone around it yellow and necrosed. The dura mater was perforated over the tympanum, its arachnoid surface being covered with a thin layer of lymph, but not discoloured. The bones of the spine were healthy, but there was a quantity of thick pus in the canal, external to the dura mater, which was thickened and opaque, and there were small ecchymosis on the pia mater of the cord. Dr. Goodhart thought that the pus must have found its way into the spinal canal from a collection which had formed high up about the fauces and base of the skull. The cord itself appeared healthy. The opposite tympanum also contained pus. Lungs healthy. At the base of the tongue, baring the thyroid cartilage, was an abscess about as large as a walnut. There was pus in the anterior mediastinum, which had extended from the abscess over the sternal end of the left clavicle. Heart, liver, spleen and kidneys healthy. Collections of pus beyond those already mentioned were found in the left pectoral region and elbow-joint; on the dorsum of the right hand; in the left sacro-iliac articulation, psoas sheath, and hip-joint; in the right psoas sheath extending down to the lesser trochanter, which was bare and necrosed; and on the dorsum of the right foot. The pus in all cases was of a thick and not caseous consistence, and under the microscope showed abundance of granular pus corpuscles, and, after the addition of liquor potassæ, some very minute and still bacteria of rod and beaded forms.

It is possible that the origin of all this was simply a collection of irritating secretion in the ear of a previously unhealthy child.

CEREBRAL TUMOUR.

(Reported by Mr. Ernest Field.)

The following case is of interest from the fact that the only prominent symptoms at the commencement of the patient's illness were of a psychological nature.

G. S., æt. 49, was admitted into St. Luke's Hospital for Lunatics on October 13, 1874. No better description can be given of his mental condition at this time than by reproducing the facts indicated in his medical certificate as showing him to be of unsound mind.

They were as follows:—

"Incoherent. Imagines he is not in his own house

Thinks he has been working hard when he has done nothing of the kind. Believes he is some other person. Gets out of bed, and says he wants to go home. Does not get up usually unless pressed to do. Says people are in the room, and others have visited him whom he has not seen. Fancies he is leading a gipsy life. Loss of memory. Semi-comatose."

These symptoms had been present for several weeks before his admission.

With regard to bodily condition, he complained of slight headache, and appeared somewhat weak: the left leg seemed a little wasted when compared with the right, but the man could walk very fairly. Beyond this there was nothing very noticeable about him. A suspicion was at first entertained that his might turn out to be a case of general paralysis, but this idea was given up some time before his death.

Gradually he lost power in his left side, and became quite hemiplegic; lay in bed for days in a lethargic condition, with no pains, and expressing himself as quite comfortable. His mental condition remained much as before; it certainly was no worse.

From time to time he would become quite insensible, breathe stertorously, and be to all appearance in a dying state; some hours afterwards, however, he would rouse up and take food.

Finally, on Nov. 23rd, he had one of these attacks, but on this occasion attended with squinting and unequal pupils, and after a few hours died.

P.M. A cancerous tumour, the size of a pigeon's egg, was found on the right side at the base of the brain, close behind the fissure of Silvius, pressing extensively on all the parts around and causing commencing absorption of the petrous portion of the temporal bone.

It will be noticed that during the progress of this case there was no sickness, and but slight pain in the head. Also, there was no meningitis on the left side nor effusion into the ventricles; thus negativing the statement made by Professor Niemeyer, in his text-book, that mental symptoms are absent in cases of cerebral tumour unless one of these conditions is present or the tumour is bilateral.

Obstetrics.

LYING-IN CHARITY.

STATISTICAL ACCOUNT FOR DECEMBER, 1874.

Number of women confined			222
Single births	210		
Double births	1		
Total number of children			224
Of the children born, there were living males ...			128
,, ,, dead males ...			3
,, ,, living females ...			91
,, ,, dead females ...			2
Total			224

Presentations—Vertex, 211; breech, 9; hand and head, 1; footling, 1; face, 2—total, 224.

Operations—The long forceps were used once.

There were four maternal deaths—3 from puerperal peritonitis, and 1 from broncho-pneumonia.

Of the women confined there were—

In the 1st confinement		26
,, 2nd ,, ...		39
,, 3rd ,, ...		26
,, 4th ,, ...		32
,, 5th ,, ...		28
,, 6th ,, ...		16
,, 7th ,, ...		21
,, 8th ,, ...		13
,, 9th ,, ...		7
,, 10th ,, ...		7
,, 11th ,, ...		2
,, 12th ,, ...		4
,, 13th ,, ...		1
,, 14th ,, ...		1
,, 16th ,, ...		1
Total		222

REPORT OF THREE CASES OF PUERPERAL PERITONITIS.

A. W., æt. 21, unmarried, was taken in labour about 4·30 p.m. on Nov. 30th. On the evening of Dec. 1st an extern was called in. Up to 1·30 p.m. on Dec. 2nd the pains were pretty strong, but after this they became weaker. At 4 p.m. the os was fully dilated and the membranes ruptured, the head being in the vagina and not advancing. At 8 p.m. the junior in the charity saw her, pulse was then 108, pains very feeble. At 10 p.m. the senior saw her, and fetched Dr. Galabin, who arrived about 12 midnight. The senior then applied long forceps and delivered, with great facility, a living male child. The uterus firmly contracted, and there was no trouble.

Dec. 3rd. Pulse 98; temperature 98·6.

Dec. 4th. Some pain last night. Had to take an opium pill. Temperature 104; pulse 144. Some abdominal tenderness, slight tympanitis. Ordered four grains of quinine three times a day.

Dec. 5th. Temperature 104; pulse 130; respiration 32. Symptoms in no way more marked. Bowels open once. No vomiting. Still some tympanitis. Quinine continued.

Dec. 6th. In the morning she was apparently rather better, tongue cleaner, abdominal tenderness and distension less. Temperature 102·8, pulse 140, respiration 32. But patient was excitable, and was vomiting a greenish vomit. Ordered an effervescing mixture containing morphia and prussic acid. Quinine continued. Ice, brandy and milk. At 3 p.m. all the bad symptoms had increased, severe vomiting and purging came on.

Dec. 7th. Patient prostrate, vomiting coffee-ground material; pulse small and rapid, extremities cold. She died about noon.

L. S., æt. 21, unmarried, was confined on Nov. 27th. The labour was natural, but the child, which was very weakly, died twenty-four hours afterwards.

Patient was attended daily by the extern until Dec. 2nd, when he called in the junior in the charity, who found the temperature 103, pulse 140, patient looking flushed and ill, discharges almost stopped, no vomiting, slight abdominal tenderness. Ordered mist. ammon. acet. 1 ℥ three times a day, and a grain of opium at night.

Dec. 5th. Patient rather worse, some sickness and

abdominal pain. Temperature 103·6, pulse 150. Ordered four grains of quinine every four hours, and brandy and milk *ad lib.*

Dec. 6th. Much abdominal pain and tenderness, vomiting and purging. Temperature 103·8, pulse 140.

Dec. 7th. Patient died at 6 p.m.

S. B, æt. 32, was delivered of her seventh child on Dec. 11th. Easy labour; male child, living and well.

Dec. 13th. During last night abdominal pain and vomiting came on, patient had been drinking freely of gin the day before, and her pain was ascribed to this. Temperature 102·4, pulse 130. Ordered mist. ammon. acet 1 ℥ every four hours, and a grain of opium every three hours.

Dec. 14. Pulse 130, temperature 101. Much tympanitis, continued vomiting. Ordered four grains of quinine every four hours, and continue opium. Vagina syringed out with permanganate. Ice, milk, &c., ordered.

Dec. 15th. Tympanitis excessive. Abdomen greatly distended. Pain very severe. Pulse 120, temperature 99. Vomiting incessant. Quinine and opium continued.

Patient died early on the morning of the 17th.

Remarks.—It will be seen that death took place on the fourth, tenth, and sixth days respectively. All the cases were treated freely with quinine and opium, one of them from the earliest onset of the symptoms, but in none was any benefit whatever observed. The principal symptoms noticed in all were abdominal pain, tympanitis, and vomiting; these rapidly running on to complete prostration and death, the patients being sensible to the last. It did not appear that there was any possibility of infection, although all the cases occurred about the same time. The patients lived a long way apart, were attended by different externs and were not seen by the same person until the symptoms were pronounced.

No history of infection from scarlatina or other virulent poison could be found, and all the patients had been in good health up to the time of seizure. It may be remarked, however, that just at the time there was an unusual amount of pyæmia in the wards of this and other hospitals, and an explanation may possibly be found in the infection of the atmosphere by bacteria or other poisonous germs. No post-mortem examination was made in any of the cases.

The Wards.

—o—

MEDICAL.

The following Cases were admitted between Jan. 6 and Jan. 13:—

Mary.—3—Pyæmia—death. 20—Bronchitis. Cot—Chorea. 21—Dysmenorrhœa. 26—Ruptured perinæum. 32—Cellulitis. 33—Retroflexion. 40—Pelvic hæmatocele.

Addison—2—Hysteria. 5—Acute rheumatism. 8—Phthisis. 9—Acute rheumatism. 10—Acute rheumatism. 11—Phthisis. 21—Gastralgia. 23—Eczema 25—Chronic rheumatic arthritis. 28—Tubular nephritis. 29—Sub-acute rheumatism—mitral regurgitation, 30—Carcinoma of liver, &c. 35—Diabetes. 36—Pyrexia.

Stephen—3—Apoplexy. 24—Rheumatism 30—Phthisis and emphysema. 34—Tubular nephritis. 37—Hypochondriasis. 42—Tubular nephritis—morbus cordis. 46—Acute myelitis. 49—Hysteria (male) 50—Synovial rheumatism.

John—3—Pneumonia. 4—Phthisis—pneumonia. 10—Morbus cordis.

Miriam.—17—Chorea. 22—Phthisis—pleurisy. 23—Peritonitis. 31—Pneumonia.

Philip—1—Osteo-arthritis. 3—Chronic bronchitis—emphysema. 7—Aortic disease. 10—Pneumonia (apex)—Acute phthisis (?) 14—Hodgkin's disease. 19—Aortic disease. 24—Aortic disease.

Bright—3—Chorea. 10—Acute rheumatism.

SURGICAL.

The following cases were admitted between Jan. 7 and Jan. 13:—

Astley Cooper—30—Stricture (traumatic). 33—Varicocele. 34—Necrosis of femur. 36—Stone in bladder. 39—Strangulated inguinal hernia. 40—Epithelioma of lip. 44—Stricture.

Job.—2—Stone in urethra. 6—Compound fracture of tibia and fibula. 8—Compound fracture of tibia and fibula. 9—Extensive laceration of fore-arm—amputation. 17—Compound fracture of tibia and fibula. 18—Railway crush. 19—Necrosis of tibia. 24—Fractured tibia.

Lydia.—2—Pott's fracture. 19—Fractured tibia and fibula. 22—Strangulated femoral hernia. 23—Abscess of thigh. 24—Fractured tibia and fibula. Cot—Paraphymosis.

Lazarus.—16—Syphilitic ulcer. 19—Ulcer of leg.

Martha.—2—Disease of ankle joint. 14—Diffuse inflammation about knee-joint. Cot—Burn.

The late Edward Hunt.—The subscription list in aid of the widow of the late Edward Hunt, one of the bathmen to the hospital, will be closed in a day or two. A few old Guy's men, noticing the announcement of his death in last week's "Gazette," have kindly sent up subscriptions. If there are any others who would like to do the same, Post Office Orders can be sent payable to Mr. Henry Williams, at the Borough Post Office. The amount collected is at present £45 10s 6d

At the Shipton railway accident, a man, æt. 50, sustained a compound comminuted fracture of the ankle-joint. He was taken to the Ratcliffe Infirmary, where the limb was placed on a back-splint, and the wound closed by lint soaked in the blood. He has not had a bad symptom.—*Lancet.*

Professor Bilroth has recently performed his second operation of removal of enteri-larynx for epithelioma of chordæ vocalis. The patient died in a few hours apparently from pneumonia.—*Medical Times and Gazette.*

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Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 18. SATURDAY FEBRUARY 6, 1875. TWOPENCE

TYPHUS fever is a somewhat rare malady for us to see in this hospital, and we are therefore fortunate in being able to supplement these few remarks upon it (especially with regard to its connection with Typhoid Fever), by the report of two cases lately in Addison Ward, under the care of Dr. Habershon.

Although the two fevers are rightly separated in our text-books, by distinctions so rigid as to render fallacy well nigh impossible, we must bear in mind that practically their early diagnosis is attended with the greatest difficulties, and, also, that between the typical forms of these two fevers there exists an unsorted mass of febriculæ, abortive typhoids, &c., which greatly hamper any defined diagnosis.

And yet a diagnosis, and an early one, too, is of the greatest importance, for on it depends often the prognosis and the proper adoption of Hygienic measures.

Thus, if a patient very prostrate with fever, having been ill six or seven days, be clearly discovered to have typhus, the prognosis is infinitely more favourable, for prostration is always early shown in this fever, while a similar condition in typhoid would lead us to infer that the patient's strength would not hold out against the more protracted attack, which had not in all probability reached its height.

The aspect of a typhus patient is peculiar, the general dusky lividity and suffused conjunctiva, contrasting well with the pallor and hectic flush of typhoid, but if in the latter there be much bronchitis, to which there is a special tendency, the face becomes more or less livid.

There is often in both, at the onset, an erythema, most marked on the arms and chest, and this, with the frequent slight sore throat in early typhoid may render its diagnosis from scarlatina exceedingly difficult.

The rash in typhus generally appears on the fifth day, and becomes petechial in two or three days more, thus some idea of the period of the fever may be arrived at. The rash is sometimes absent in young subjects and in mild cases, agreeing with the general rule that the severity of the attack is in proportion to the intensity of the rash.

In typhoid the rash is often absent, appears irregularly, and is no measure of the severity of the attack.

The tongue in typhoid is generally covered with a thick yellow central fur, the edges and tip being red, it has probably some connection with the bowel irritation, and therefore it aids in diagnosis.

The abdomen in typhoid is tumid and tender, being transversely distended, "tub belly," in contra-distinction to the "pot belly" of ascites and general obesity. The abdomen in typhus is natural; if any swelling and tenderness, it is in the hypogastric region, and denotes retention of urine, to which there is great liability.

Disturbance of the bowels is nearly always present in typhoid. Generally there is diarrhæa at some period; in one case seen lately, the bowels were only moved twice during the last fourteen days of the fever, and then only in response to an enema, nor in this case (which is not very uncommon) had there been any previous diarrhœa.

The diarrhœa is no measure of the bowel affection, but is dependent on the attendant congestion, thus in a most severe case lately seen, with most copious diarrhœa, and death on the twenty-fourth day, only one cicatrising ulcer, half an inch in diameter, was found.

Hæmorrhage, also, from the bowel, does not always arise from ulceration into a vessel, since it may occur at a time when there are no ulcers, or when at least they have a healthy cicatrising surface, the bleeding in these cases is from the general surface of the mucous membrane, and is often accompanied by epistaxis, hæmatemesis and bleeding from the gums.

The temperature affords us little or no aid to the bedside diagnosis of these two fevers, for we rarely have any record of the first few days of the fever, when the character of the rise would probably be of great service; it is often only on reviewing a completed chart that we recognise their differences. The marked morning and evening fluctuations in typhoid generally only occur late on in the fever, just before the temperature settles down to normal; the variations are, however, throughout more marked than in typhus, where a tolerably uniform line of temperature, with a sudden fall, is generally seen.

The period of highest diurnal rise of temperature in typhoid varies somewhat, it is nearly always some time between 4 and 8 p.m.; it is generally stated that the afternoon temperature is the highest, but in most cases the temperature at 8 p.m. is still higher, it remains high till about midnight, and then quickly falls, so that the lowest temperature will be reached at 4 or 8 a.m.

These remarks probably hold good in all continued pyrexical conditions.

In early convalescence, if there be no complication, the body heat usually falls below normal for a few days.

The build of a patient certainly influences the prognosis—heavy, thick set people standing fever far worse than the more spare ones.

Those in continuous attendance upon typhus patients, if attacked, generally suffer severely, and the mortality among them is exceptionally high.

If a typhus patient be pregnant, the contents of the uterus are nearly invariably expelled, whether the attack be mild or not. This, of course, gravely complicates matters, but causes by no means such serious results as pregnancy with scarlet fever.

The duration of typhoid is fully twenty-eight days (if the history be carefully taken) and is more commonly over this time than under.

Our treatment of these fevers is unsatisfactory, we can neither ward off nor cut short an attack by any yet known means. Our efforts are, therefore, to be directed towards sustaining the patient's strength, and on its slightest failure to use stimulants freely and at short intervals.

Much may be done to relieve symptoms as they arise.

Thus the diarrhœa of typhoid is best checked by opium given internally; if used as an enema, thirty drops (or more) of laudanum in a drachm of mucilage is best.

The restlessness also, so frequently amounting in typhus to furious delirium, is best treated by morphia, which is well borne, and may be given with an unsparing hand.

In concluding these remarks, although great stress has been laid on the importance of correct diagnosis, no pretensions have been made to do more than direct attention to a few interesting points, and especial care must be taken not to lay stress on any individual sign or symptom, no one of which is pathognomonic in diagnosis, nor fatal as regards prognosis.

A STUDENT'S NOTES OF

Lectures on Midwifery.

By J. Braxton Hicks, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

Lecture XIII.

There is another rule which I may as well mention here, namely, *not to give secale if any obstacle to delivery is expected unless we are prepared to render assistance when the pains have been roused.* I have seen the former portion of this rule enforced, but this is limiting our use of secale too much. Unless we have instruments, &c., close by, then the rule holds good. As an instance of the employment of this drug under these circumstances, I may mention a case. I was sent for in consultation to a patient who had been a long time in labour. The pains had subsided. Two doses of liq. secale had been given, but without any result. The uterus was still motionless. It was not in a permanently contracted condition. I therefore repeated a third dose. I waited an hour without result. Thinking perhaps the preparation was at fault I gave twenty grains of the powder, boiled in water, and drank with the dregs. In a quarter of an hour the uterus was in full action. Now we had suspected some obstruction from noticing the size of the pelvis. I was therefore ready with the forceps. After waiting fairly and finding no advance, the forceps were applied, and the child delivered, an active uterus making the remainder of delivery safe and natural. The same would occur in a very contracted pelvis; if the uterus should fail in its activity in this case even if we perforate first (supposing we do not think it advisable to turn upon rules I shall by and by lay down for you) we are much assisted, and no danger is run if we arouse the uterus into action before we draw down the child. It is difficult to lay down rules as to when it is urgent, in cases of uterine inactivity, that we should stir it up to action. I remember in my younger days, allowing the head of a premature fœtus rest to on the perinæum for twelve hours, at the end of which time there was one pain and the child was expelled. The administering of a dose of secale would at any time rouse "pains"; still, as there was no pressure, and as no ill resulted, there was no necessity. The pulse remaining good, and no aberration from normal state existing, we may elect to wait

without serious harm; it may be more convenient to get the labour over, and we shall not be acting wrong in hastening matters. But when pulse rises, feverishness begins, and patient becoming anxious, fretful, and irritable, it is as well, the path for the exit of the child being clear, to give a dose of secale, especially if we have tried the perhaps milder though less certain measures at our hand for stirring up "pains." When the case is well selected, the full dose of secale from half a drachm to one drachm acts more satisfactorily as an expellent than small frequent doses. The latter tends to irritate the uterus and retain the child. If the uterus, however, be violently roused to expulsion, while the passages are unprepared or obstructed, then the uterus may injure and rupture itself, or may tear down the obstacle, rending the vagina or perinæum, or damage the child by pressure, or crush its cranial bones, or rupture the longitudinal sinus by too much overlapping.

I prefer to give it in the form of powder, twenty to thirty, or even forty grains boiled in water, and the whole taken; this may be repeated in twenty or thirty minutes. There are many preparations, which can be given if proved to be good, in the equivalent doses. The œtherial tincture keeps well and is efficient, but nauseat and liable to cause vomiting. It is prompt and may be useful in post-partum hæmorrhage. A preparation called ergotine has been employed in about four-grain doses injected subcutaneously. It is said to be very efficient and rapid in action, but personally I have not sufficient experience of it at present to speak of it more. It will be a very great advantage if ergot can be made to act promptly. Given in the form of a powder it is slow, even when previously boiled. It is more efficient if we employ the liquor or tincture, still it is then very slow for such cases as post-partum floodings. In ten minutes the crisis has often passed with one of two terminations, thus, although secale is good in the milder cases of flooding; it is practically useless in the sudden forms, except its action comes in after, when our more active treatment has succeeded, to secure permanent contraction. It is a questionable point whether large doses of secale do not depress the heart' saction, so much as to render its employment to be avoided in extreme cases of flooding. I am inclined to think that it has this effect; but this will not affect our employing it in cases without violent flooding. If, in cases of flooding before labour we want to increase uterine action we may generally employ it, unless the patient be nearly pulseless. It is always a great comfort to feel that when the child is born, the uterus will most probably be in an active state from the previous dose of ergot.

It has also been supposed that ergot is poisonous to the child. For myself I have no proof of its po'sonous properties, but I have often seen it kill the child. If you give it in ill-suited cases; I mean where the uterus, as in many primiparæ, is already irritated, where it has already half-asphyxiated the child, by pressing on the funis, placenta, and half closing the sinuses, then a dose of secale will go far to ensure its death; or if impaction be already present, and the suture overlapping, then the parts inside cranium are pressed upon so hard as to extinguish life, or at least to damage the brain as to make the child an intellectual wreck. Given in moderate doses, and in true inertia, I know no drug which is so certain of producing the desired effect.

NOTES ON THE MICROSCOPE.

(From Dr. Pye-Smith's Demonstrations of Practical Physiology.)

Human Histology, the knowledge of the tissues (or textures) of the human body is also called Physiological Anatomy, because the functions of the organs are in most instances dependent on their minute structure, and General Anatomy, because, as Bichat first showed, the same elementary tissues make up the apparently different organs of the body; and, lastly, Minute and Microscopic Anatomy, because the elements of these tissues are too small to be seen by the unaided eye. The instrument, then, for studying Histology is the Microscope.

A concave mirror magnifies by reflexion, a bowl of water by refraction. In practice all our magnifying instruments consist of one or more glass lenses. The first discoveries in Histology were made during the latter half of the seventeenth century by single bi-convex lenses, either carried in the hand and variously fixed for convenience so as to form a "simple microscope." Soon after the Royal Society was founded (1664), the "Micrographia" of Hooke, the "Anatomy of Plants" by Dr. Crew, and the "Anatomia Rerum" of Leenwenhock, proved how well these observers could use the new instrument of research. During the came period Swammerdam discovered the blood corpuscles of the frog, and his countryman, Leenwenhock, those of man; Bartholin, a Dane, completed Ardle's account of the lacteals by demonstrating the other lymphatics, Malpighi detected the capillary circulation in the frog's foot, and the ultimate air-vesicles of the lungs; and another Italian, Redi, made the important observations which disproved spontaneous generation.

The simple microscope, which was the instrument of these great advances in knowledge is not entirely superseded. You should always carry a pocket lens with you in the wards as well as in this room; and make it a rule to examine every tissue you deal with here, first with the naked eye, and then with your lens, before you put it under the microscope. The only use, however, of a more elaborately constructed "simple microscope" is for dissecting.

Whether you use one or more lenses, so long as there is only produced a magnified image on the retina, the instrument is a "simple microscope." The "compound microscopes" you will use in this class are contrived so as to magnify again the image thus formed. The first lens, or combination of lenses is called the object-glass, or objective, the second which magnifies the magnified image the eye-glass or eye-piece. The effect of this, of course, is to magnify any defects in the objective, and hence the compound microscope was an unsatisfactory instrument until the great improvement in the manufacture of achromatic objectives, which was made by Professor Amici, of Modena, about fifty years ago. This explains the curious fact that the microscopical discovery is divided into two epochs, that I have already referred to in the seventeenth century, and that from about 1826 to the present time.

It is obvious that the most important part of a microscope will be the Objective. This consists of several lenses combined so as to increase the magnifying power while mutually correcting each other's spherical and chromatic aberration. The former depends on the unequal refraction of the rays of light which fall on the central and those which fall on the peripheral parts of the lens, the latter upon the unequal refraction of the several coloured

rays of which white light is composed. In a good objective, then, the objects in the outside of the field should be as distinct as those in the middle, and there should be no rainbow-fringes round the objects. English opticians call their objectives 1-inch, ½-inch, ¼-inch, and so on, meaning that the combination of lenses which make them up are equal in power to a simple lens of 1-inch, ½-inch, or ¼-inch focal length. You will find practically that you must bring your objective much nearer the object than its nominal focal distance, and that the "¼-inch" lenses of different makers are very different in magnifying power. Continental makers name their objectives by numbers, the lowest being the weaker, the higher ones the more powerful glasses. Some objectives are constructed to work with a drop of water between them and the cover glass, so that the rays from the object only pass through glass and water, not through air till they reach the object-glass. The immersion lenses are advantageous in some respects for the higher powers, but are more troublesome for beginners. With high powers, the focal distance is so short that you need "extra-thin cover-glasses" to get the object-glass near enough to the object. With them, also, you may need to make a correction in the mutual distance of the component lenses according to the thickness of the cover-glass used. For ordinary purposes of Histology and Clinical Medicine you will find that an objective with good definition, clear light, flat field and freedom from coloured fringes is sufficiently powerful if equal to Hartnach's No. 8, and to the "fifth" objectives of the best English makers. When familiar with this power, by all means buy higher ones: foreign immersion lenses are the cheapest and perhaps the best. There is no object in having more than one "low power." An "inch" objective can be increased by deep eye-piecing very pleasantly, and for lower powers a simple lens is better.

The next most important part of a microscope is the EYE-PIECE or second magnifying lens. This, like the objective, is a combination (usually that devised by Huyghens) of glasses—one below, the field-glass, and the other next the eye, the eye-glass. These not only correct each other, but also serve to redress the frequent "over-correction" of the objective. A diaphragm, placed between the two, limits the field by cutting off the peripheral rays which are most affected by spherical aberration. You should have two eye-pieces, the "shallow" or long one, which is the weaker, and the "deep" or short one which is the stronger. Very deep eye-pieces are not desirable, first because they lose so much light (a necessary result of all magnifying), and secondly because they exaggerate any want of definition in your objective.

The TUBE which holds the eyepiece and objective should be of good diameter, and provided with a draw-tube. By pulling this out you increase the magnifying power of your instrument with only slight loss of light.

For moving the instrument until the object is in focus you have a coarse and fine adjustment. Use the former, whether by sliding the tube in a collar or by rackwork, to find the object and get it in focus: keep your finger on the latter while you are examining it, so as to bring the deeper and more superficial parts of it into view successively.

Foreign microscopes are usually made with a perpendicular, English ones with a sloping tube. It is very much a matter of habit which you prefer. The former is less expensive, and enables you to dispense with all appartus for your stage. The latter allows of a longer draw-tube, is sometimes more convenient for the light, enables you to see the camera lucida, and is generally found less fatiguing. There is no reason why instruments should not be made on the Hartnach model with a hinge, and two London makers (Messrs. Crouch and Baker) have adopted this plan.

If the STAFF is not horizontal you must have a ledge for your glass slip, but other fastenings are usually in the way. Even if you have a moveable stage I prefer one which you can push with your fingers to any contrivance of rackwork or levers.

The MIRROR should be sufficiently large, and it is well to have a concave as well as a plain side to it. A DIAPHRAGM to regulate the light from the mirror is seldom required.

All that is necessary for the STAND is that it be steady. This is best accomplished by a heavy tripod or horseshoe foot. Wooden boards are generally unsteady.

(To be continued.)

JABORANDI.

We have been favoured with a specimen of the new drug, Jaborandi, by Mr. Gerrard, a late dispenser at this hospital. Enough has already been said about the properties of this drug, we will, therefore, content ourselves with a short discription of the results obtained from the three drachms of powdered leaf forwarded to us. Two drachms were converted into tincture by careful percolation with rectified spirit, the third was infused in boiling water. A patient in in a febrile condition, suffering from acute tonsillitis, and with a dry skin, was selected, and the equivalent in tincture to two scruples of the powder was given in water. In about a quarter of an hour the skin was moist, and the saliva collected more rapidly than it should do. A repetition of the dose augmented these conditions; a gentle perspiration was maintained for three or four hours, and three or four ounces of saliva well expectorated besides what was swallowed. The febrile symptoms were certainly less marked or the following morning. Next a case of chronic Bright's disease was selected, in which vomiting and headache had just appeared, accompanied by a diminution of the quantity of urine. The skin was not moist. A time was chosen when the irritability of the stomach appeared to have quieted down, to give the patient the infused powder; the whole was swallowed, includiug the dregs, but unfortunately returned in less than ten minutes. Nevertheless, a certain amount of sweating was produced, with a flow of about two ounces of saliva. Six hours afterwards, the remaining tincture (the equivalent of two scruples of powder) was administered, and, although there was retching not very long after, the patient continued in a gentle perspiration all night (the dose was taken at 9 p.m.) and about seven ounces more saliva were collected.

This experience is, of course, too limited to be of much value, but Jaborandi will probably have a good trial at Guy's, and from its marked action as a Diaphoretic and Sialogogue bids fair to prove a useful addition to our Pharmacopœa.

We are indebted to Dr. Wilks for his kind permission to try the effects of Jaborandi on the above cases.

Mr. Ernest Field, M.R.C.S., L.R.C.P., Lond., has been appointed Resident Medical Officer of the Bath Hospital.

In Memoriam.

WILLIAM ERNEST SNOOK.

Died Dec. 3, 1874. Æt. 22.

Few, probably, of those to whom Ernest Snook's pale, intelligent face and delicate form were familiar, are aware of the care and anxiety that he smothered under the comic, nervous, yet genial manner, which was peculiar to him. The son of a country surgeon, with a large family, whose practice was extensive but repaid, in great part, only by the love of the poor whom he attended, he received the best education the slender means of his parents could afford him, and was then, at his own request, entered for the medical profession. The entrance barrier in Arts, his school education had little prepared him for; but refusing all aid that might reduce the income of his parents, he passed this examination creditably, and entirely by his own exertions.

He commenced work as a student at Guy's in October, 1871, but, within a fortnight of his entrance, he was called away to attend the death-bed of his father. The resources of his remaining parent were now much straightened, and when our late comrade returned to the Hospital, it was with firm determination to work to the utmost of his power, and to be as little burden as possible to his widowed mother. A few months later, he was discovered cheerfully at work, surrounded by bones and books, in a wretched bed-room, destitute of every comfort and lacking even what are usually considered the necessaries of life. His friends insisted on placing him in a more airy and comfortable lodging, which he afterwards shared with a younger brother, to whom he was much attached. To this change he consented with reluctance, assuring his mother that he would have been happy in an even meaner apartment, provided she was unhampered by his expenses. In his second year, previous to the primary examination at the Royal College of Surgeons, he fell in Mr. Lucas's class, and was selected to go up with the more advanced students in the first batch. Indeed, he had so thoroughly mastered Gray's Anatomy as to be able to repeat a great deal of it by heart, and was often jokingly called by his associates a "walking Gray." At this examination he obtained three "goods," the highest marks awarded, and, encouraged by his success, worked on for the hospital prizes, at which he was so fortunate as to be placed second, obtaining a prize of £30. In his third year he read a paper before the Physical Society, on "Puerperal Convulsions," and in the summer succeeded in retaining the position he had gained in the preceding year, by again carrying off the second prize of £25. Soon after this he passed his final examination at Apothecaries' Hall. It was now his great desire to wait another year in order that he might take a dressership and pass his College, but this he gave up, unasked, and left the hospital to assist an eminent surgeon in large practice in Lancashire, whereby he relieved his mother of the burden of supporting him; in this way he had been employed only two months, when he was attacked with rheumatic fever, of which he died after an illness of five days. Ernest Snook's life was one of pure unselfishness and self-denial. A most laborious worker, he would scarcely, but for the affectionate care of his younger brother, have thought of himself enough even to take sufficient food, and his nights were constantly broken by attendance on midwifery cases, often undertaken out of pure good nature for friends, to whom he afterwards gave the cards. His originally somewhat delicate constitution, over-strained by excessive work and unrefreshed by sufficient sleep, broke down in its first grave conflict with disease, and we, who were lately his comrades, are left to mourn the loss of one, whose life was an example of goodness, and whose premature death will be long regretted.

Correspondence.

We do not hold ourselves responsible for opinions expressed by our correspondents.]

THE BAVARIAN SPLINT.

To the Editors.

Sirs,—The account given in your last week's "Gazette" is certainly a great improvement on the one given in Mr. Bryant's work on Surgery, but there are a few points to which I would like to direct your attention.—1st, "stout flannel" is spoken of. Now, the flannel which is most serviceable is the common house-flannel, the coarser the better. But before using it you must see that it is well shrunk, or else you will find that your splint will fit much too tightly and cause pain.

The next point is the stitch, which is not the stitch used in hemming, but a stitch which goes by the name of the back-stitch, which has the advantage of drawing the part tighter together and preventing it coming undone.

Again, you should smear the second layer of flannel well over with gum and chalk, before proceeding to stitch it to the first layer. This adds much to its strength, and is especially important in knee and thigh cases.

Another point, not alluded to, is that the foot should be kept at right angles to the leg, by means of a bandage carried round and fixed to the toes, until the splint is nearly dry.

I need hardly add that a great advantage is obtained by placing a patient near the fire in winter, or near an open window in summer, so as to aid the drying. The account speaks only of a Bavarian splint in respect to its application to the leg. But in the ordinary run of fractures of the leg, the plan as suggested, I believe, by Mr. Dunnage, of placing two gummed and chalked stockings over the leg, one being larger than the other, answers admirably, and has this advantage over the Bavarian, that it does not take more than five minutes to apply, whilst the Bavarian cannot be done much under the half hour.

But it is in the hip, knee, and thigh cases that the Bavarian is of the greatest service.

In making one for the hip, it is necessary to place a piece of common brown cardboard of a rectangular shape previously moistened by boiling water, so as to prevent the creasing (which is the chief trouble in these cases) in the fork of the leg, as you cannot persuade the small individuals for whom it is mostly used, to remain in so quiet a state as the case demands.

In a knee case it will be found much better to make the seam on the outer side, so as to give greater evenness and strength to the knee in front, turning the edges down at both the upper and lower ends.

If it is wished to keep these splints for any length of time they may be coated with varnish; and as a proof of the

success of the Bavarian splint, when properly applied, I may mention that I made one for a case of pulpy disease of the knee-joint, which lasted over a year, and was in constant use, iron splints made by well-known instrument makers having previously failed.

It is to be hoped that with all its advantages the Bavarian splint will come into more general use, as the mentioned case shows that in endurance it surpasses many of those elaborate instruments you so often see in instrument maker's windows.

Yours, &c.,

Edward J. Hicks.

THE FOOTBALL CLUB.

To the Editors.

Sirs,—For some time there has been a storm brewing about the difficulty there is in getting men to play for the hospital football teams, and I am glad to see that it has at last burst, as shown by a paragraph in a late number of the "Gazette."

Your communicant complains that the men will not play for the second team, and gives as a reason "that they prefer playing for other clubs, where, perhaps, they are thought more of." No doubt they do *now* prefer playing for other clubs; but why did they join these clubs in the first instance? I will try to explain.

Last year a large number of the fresh men were football players, and on entering the hospital, they naturally wished to play in the football teams, consequently many of them gave in their names, and signified their desire of joining the football club, but no notice was taken of this, and not one of them was ever asked to play; but the teams, especially the second, were made up of men of a certain "clique" without regard to merit. The first year's men, therefore, seeing that there was no chance of playing, joined other clubs, in which they are now interested, and to which they are to a certain extent pledged, and accordingly do not like nor care to leave.

Again your communicant says "that it is absurd for men to take offence because they are not asked to play for the First Fifteen." Now, this is very unjust; for I am sure that none of them expected or even thought of being placed at once in the First Fifteen, but I have no doubt that they all hoped one day to achieve that honourable position.

I trust and believe that now that the men see that the players are being more fairly chosen, they will give up their other clubs for the sake of keeping up the hitherto good name of Guy's Football Club.

I hope that in fairness to last year's men, you will insert this explanation in the next number of your Journal.

I am, Sirs, yours obediently,

Justitia.

We remind our readers that the list of appointments to be made for the ensuing three months is now posted in the colonade. Applications must be made at the Medical Office, between the hours of ten and twelve, and the list will be closed on the 11th inst.

Mr. A. G. Lacey passed his final examination at the Apothecaries Hall on Thursday, the 28th ultimo.

At the meeting of the Physical Society this evening, Mr. Shadwell will read a paper "On the treatment of Rheumatic Fever."

Post-mortem Room.

The following autopsies have been made recently;—

January 21st.

Suppurative Peritonitis (sudden death).—A sailor, who had given evidence in Westminster, and subsequently walked from there to the Mansion House, appearing to his friends to be in his usual good health, fell down suddenly, then lost consciousness, and was immediately brought to the hospital. He was then quite comatose, face livid, no pulse nor action of heart could be discovered, and in about fifteen minutes the very feeble and slow breathing stopped. Upon inspection nothing could be discovered beyond congestion of the brain and pus in the knee-joints, and in the cavity of the abdomen. For this latter there was no discoverable local cause, but the state of the knee-joints pointed to a pyæmic condition as having been present. Pyæmia, however, is not usually acknowledged as a cause of peritonitis, unless some structure in proximity to the peritonæum is first affected.

Peritonitis in a woman, æt. 30, from 23, Miriam Ward. History showed an injury to the right lumbar region, by a fall seven weeks ago, followed by the passage of a clot with pain per vaginam. During life nothing existed to determine what was the cause of complaint. There had been retention of urine, followed by frequent micturition. Abdomen distended, painful and tympanitic. The autopsy showed intestines greatly distended and matted closely together. A large clot, evidently not very recent, was discovered in the pelvic cavity in the recto-uterine pouch. The uterus and ovaries were healthy. The uterus did not appear as if there been a recent miscarriage. There was a doubtful corpus luteum. No further light could be shed on the determining cause of the hæmorrhage into the peritoneal cavity.

January 22d.

Phthisis.—A case in which there had been rapid disorganisation of the lung. The left lung was nearly half destroyed by a cavity of exceedingly irregular form. This had given rise to amphoric breathing, and bruit de pot félé as low as the fourth rib. No tubercle was found in the lung, the morbid process appearing to be purely inflammatory, but against this supposition an ulcer was found in the intestine with tubercles on its peritoneal surface, and another in the larynx.

January 23rd.

Phthisis and Ulceration of Tongue, the latter appearing to be tubercular.

Bronchitis and Emphysema—Gout.—The heart generally was found to be hypertrophied, the right side particularly, owing to the lung trouble. There was no evidence of any deposit on the valves, and yet there were large infarcta in the spleen, which had caused obliteration of a great part of the organ. Hence arises the question as to whether a local congestion, without any embolus, can give rise to the formation of infarcts. Suppuration had taken place around the joint which had last been affected with gout, the pus also extending upwards among the small muscles of the thumb. The synovial membrane of the knee-joints was very congested, a condition apparently allied to that observed a short time since in a case of Dr. Pye-Smith's, where there was effusion of blood into the gouty joints.

Lardaceous Disease in Morbus Coxæ.—Suppuration had existed for many months past. The thyroid, liver, spleen, intestines and lymphatics were intensely amyloid, but there was scarcely any deposit in the kidneys. No albumen had been detected in the urine. There had been excessive diarrhœa. The form of the head of the bone was nearly perfect, but the ligamentum teres was entirely gone, the cartilages altogether removed, and the joints dislocated. The head and trochanter were very carious.

January 25th.

Acute Broncho-pneumonia—This was in a young woman who had only been ill ten days. The only abnormal physical signs present were over the upper part of the chest and small bright râles scattered about generally. The above diagnosis was given. The autopsy showed extensive lobular pneumonia, the whole of both lungs being affected.

Diffuse Cellular Inflammation.—In this case there was diffuse cellular inflammation in the left leg and thigh. A stricture had existed for some time, and had rendered the bladder hypertrophied and sacculated, and one kidney had suppurated in the upper half only.

January 26th.

Typhoid Fever.—This was a case fatal at about the tenth day of the disease. Temp. five hours after death was 100. Hypostatic pneumonia existed at the bases of both lungs, the usual condition in this affection. The typhoid affection of the Peyer's patches was evidently in an early stage, as there were only one or two spots where the slough could be separated, and in all the rest no "core" had formed.

January 27th.

Pyæmia.—Circumcision had been performed on the 22nd. Cellular inflammation was found to exist around the prostate and bladder, giving rise to peritonitis. There was suppuration in the prostate. Pus existed in the left knee-joint. The plugging of the veins was discovered.

Fractured Palvis and Tibia, as a result of a railway accident. The rami of the pubes were fractured on both sides, about two inches from the body of the bone. No injury seemed to have been inflicted upon the urethra. The tibia was fractured transversely just below the level of the tuberosity, and the fibula was disarticulated at its upper joint.

RESIDENTS for the MONTH of FEBRUARY.

House Physicians—Messrs. H. Hetley and F. T. Paul.
Junior House Physician—Mr. J. F. Fry.
House Surgeon—Mr. H. S. Branfoot.
Junior House Surgeon—Mr. H. Williams.
Senior Resident Obstetric—Mr. R. C. Gibb.
Junior Resident Obstetric—Mr. T. S. Morley.

The Presidents of the Physical Society acknowledge, with thanks, the following honorary subscriptions towards the support of the "Gazette"—Dr. Hilton Fagge, £1 1s.; Mr. F. Durham, £1 1s.

Operations.

Tuesday, Feb. 2.

Mr. Birket operated twice for removal of the breast. In the first case there was a large cyst, from which had been removed a large quantity of fluid by tapping only a few days previously. The cyst filled again, and, therefore, Mr. Birket determined to remove it. Upon doing so, by the usual incisions, he found that the cyst had originated in a large carcinoma, which infiltrated the pectoral muscle, forming a thick hard mass over the chest wall about 7-in. in diameter. The gland tissue had almost entirely disappeared.

The second was an ordinary cancer of the breast.

Mr. Bryant also removed a breast from a woman suffering from carcinoma.

He then proceeded to amputate a leg for very extensive disease of the tibia of long standing. The amputation was performed at the knee-joint. The anterior flap was cut just above the level of the tuberosity of the tibia. The end of the femur was removed, and a vertical saw-cut made through the patella from side to side, and the anterior portion of this bone was adapted to the cut end of the femur.

Mr. Durham removed two carcinomatous breasts from one patient.

The Wards.

MEDICAL.

The following Cases were admitted between Jan. 20 and Feb. 3:—

Addison—8—Bright's disease. 11—Acute rheumatism. 15—Consolidation of left apex. 18—Catarrh. 26—Acute rheumatism, morbus cordis. 29—General paralysis. 32—Sacro-iliac disease. 33—Morbus Brightii 34—Phthisis.

Stephen—1—Right hemiplegia with temporary aphasia, from injury to the left eye. 7—Spinal disease, paraplegia. 9—Enlarged liver. ascites. 13—Chronic gastritis. 14—Chronic vomiting. 20—Morbus Brightii. 38—Acute rheumatism. 45—Involuntary spasmodic muscular contraction.

Mary—4—Erythema in association with congenital nœvus. 6—Acute rheumatism.

Philip—9—Bronchitis and emphysema. 21—Phthisis. 33—Rheumatic fever. 34—Aortic aneurism.

Bright—1—Mitral regurgitation. 8—Phthisis. 14—Tonsillitis. 21—Tonsillitis.

John—1—Bronchitis, emphysema.

Miriam—25—Typhoid (?)

SURGICAL.

The following cases were admitted between Jan. 27and Feb.

Lude—8Hernia, reduced. 15—Fractured fibula.

Charity—3—Recurrent growth (?) 7—Absorbent inflammation, and abscess in popliteal space. 8—Fractured tibia and fibula. 9—Caries of tarsus. 13—Inflamed bursa patellæ. 14—Abscess over tibia 24—Fractured femur.

Lydia—Epulis. Cot.—Stone in bladder, necrosis of upper jaw necrosis of femur, epithelioma of rectum.

Job—1—Popliteal abscess, fistula in ano. 2—Necrosis of tibia. 2—Necrosis of os-calcis.

INDIGESTION.

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Guy's

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IN the "Coming Race" mention is made of a lady who has obtained a great scientific reputation by writing two ponderous volumes on the anatomy of the antennæ of an insect that inhabited the fore paws of a lion—to such prolixity had Science grown. It would appear that our knowledge of disease is tending in the same direction. Study the literature of any particular branch of Medicine, as epilepsy. Inquirer after inquirer records his results; book after book is written, the same stale, worthless errors are repeated times without number; wild guesses are supported by the shallowest and flimsiest of arguments; gigantic baseless theories, created by fertile imaginations, are implicitly trusted in by ignorant unthinking minds, and, when once sown, take half a century to uproot; petty details are pertinaciously sought, tiny facts are magnified to mountains, and trivialities treated as immensities.

Each disease is considered *sui generis*—as a thing distinct, apart from all others, as utterly, wholly unconnected; just as ignorant people regard the Universe as a bundle of unconnected isolated facts. Uneducated persons look on the organic and inorganic worlds as wholly distinct; the forces of Nature, heat, gravitation, chemical affinity, magnetism, &c., are believed to be directly opposed to each other, instead of being merely phases of the same grand all-pervading force.

Cats, lions, bears, wolves and dogs are regarded by them as special and distinct creations; as in no respect alike; their genealogy is ignored, their common parentage denied. Volumes on each species have been printed, but far too often each is described as a special entity; facts common to all are considered as peculiarities by disregarding their ancestry; by not recognising properties common to all (and therefore necessarily failing rightly to judge their distinctive features), views, narrow, fallacious and incorrect are propagated, and their great likeness as divisions of the Carnivora is wholly missed.

Zoologists have classified animals, have grouped large numbers together under the various heads—families, genera, species; they have traced their descent and noted their development. They have grouped them according to structural affinities. No good naturalist would devote himself to the study of any one variety, without regard to the species, genus, and family to which it belonged. Did he do so, his results would be fallacious, his work unworthy the time and energy bestowed upon it. In Medicine, on the contrary, almost always it happens that the inquirer utterly blots out of his mind all other diseases, and devotes his whole attention to one, thereby frittering away his time and that of his readers, and promulgating many most grievous errors by his contemptible narrow-mindedness.

Turn over the pages of any standard work on Medicine, the lawful judgment is "a fortuitous concourse of atoms." The distressed reader rises from the perusal thereof feeling dazed, bewildered. In his head is a small basis of fact, an immense superstructure of pure fiction. Worse still, confusion and haziness reign, where order and clearness are of paramount importance. Did inquirers view disease in a broader light, and consider each as parts of one great whole, instead of special creations, enormous advantages would accrue: odd facts would be explained and harmonised

unintelligible details be rendered clear, and hidden things be brought to light. Truer and grander conceptions would abolish the former mean, narrow, and false ideas : out of darkness would come forth light.

By the present disjointed system it is evident that the true nature of disease is missed, that wild guessing about causation, about progress, and about terminations follow; that the blackest confusion reigns where clearness and order are all-important. Till some grand mastermind like Linnæus, or Cuvier, or Buffon, or the still greater Darwin shall arise in Medicine, to disentangle our present hideous jumble, to create order, to map out broad classifications, so long shall we vaguely grope in the dark. Religion has been beautifully compared to the painted windows of a grand cathedral, which, looked at from the outside, are but blurred, meaningless daubs, but viewed from within are perfect masterpieces, where light and purpose, and harmony reign supreme. At present we look at disease from the outside of the cathedral, let us hope that the day may be not far distant ere we may be admitted to behold its wondrous structure.

A STUDENT'S NOTES OF

Lectures on Midwifery.

By J. Braxton Hicks, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

Lecture XIV.

The other stimulants which act directly on the uterus are but few and feeble, and not much employed in this country. Borax, cinnamon, and nux vomica are in some repute on the Continent. Tea, by some, has been thought to have some influence ; but, I think, like alcohol, it acts indirectly by stimulating the general powers. The stimulants to reflex uterine irritation are such as act on the rectum : for instance, stimulating enemata, purges, as aloetics : frictions on the abdomen, injecting the vagina, warm applications to vulva ; passing the hand into the vagina ; passing the finger round within the cervix, and the galvanic current, will all increase the uterine action. But in employing those which act on the vaginal surface, you must be careful lest you set up irritation, and consequent heat and dryness in the mucous membrane, with undue spasmodic contraction. They should only be done to a slight extent, just to encourage a flagging pain, and but seldom. Sometimes two fingers pressing on the inside of the perinæum before the head is actually resting on it will revive pain, but generally speaking it is best to act by gentle pressure, support, and friction on the uterus, or apply warm sponges to the vulva. Pressure on the uterus is very useful, because it increases the pressure of the head on the inside of lower portion of uterus, and thus reflex action is increased. But the same effect results from causing the patient to assume the upright position and for the same reason. But this should not be adopted too early, nor for too long a time if an irritable condition of the uterus be produced.

It is difficult to lay down any very definite rule as to the succession of these measures which you should in any given case adopt, as the conditions vary so much, but I may indicate it somewhat as follows :—Supposing, in a case where the os is fully dilated or dilatable, the pains are feeble and with long intervals, and this condition has existed for two or three hours. I should see if the patient have had sufficient sleep, if not it will be well to give say fifteen to twenty minims of laudanum, and allow her to sleep. If she have slept but is mentally depressed, the cause as much as possible must be removed. If there be a general feeling of debility it will be well to give some nourishment, with some tea, brandy and water, or wine. Some advocate a dose of quinine, and especially in those who have relaxed uterus after labour. A good bandage, if not already on, may be placed over the fundus uteri, and if the patient have rested, she may be directed to walk about the room. If the uterus be still inactive external friction can be tried. If the bowels be confined it is an excellent plan to employ a warm enema of soap and water, to which Tr. aloes 3 iij or castor oil can be added. If these resources fail we may give the patient twenty to thirty grains of ergot, as before directed, and this failing the dose may be repeated after half an hour. If the head be low down, and the perinæum well relaxed, as in multiparæ, then the dose may be larger, say 3 j. However, I generally find if you manage the surroundings of your patients cleverly, avoiding excitants or depressants equally, placing her at her ease with regard to her attendants, seeing she is well nourished, and all the functions are in order, you will very often avoid a troublesome case, which a little want of judgment would have set all awry.

Having now discussed the defective action of the uterus, let me point out its errors in excess.

I once attended a lady at the age of fifty-one in her first labour. The pains came on suddenly, like a flash. I feared lest rupture might ensue. The coccyx was very incurved and anchylosed, impeding the head's exit. I put on the forceps, the fixed bone yielded, and the danger was over.

If, in the midst of labour, an obstacle presents itself to the descent of the head, you will easily understand by the remarks I have already told you, that the uterus is roused to a greater degree of action. The amount of increased action is *ceteris paribus* equal to the increased pressure, of course within certain limits, the fœtal head undergoing corresponding compression. If the obstacle be severe, the patient vigorous, it is wonderful to see the violence of the action, the total force capable of being put forth in extreme cases having been calculated at 50lbs. for the uterus itself, and the auxiliary forces at 500lbs. This latter calculation, at any rate in practice, is, I think, far above the mark, but in any case it is very great. The suffusion of face, the sweat, the whole action sufficiently attest an enormous generation of force put forth by all the muscles of the body, and if the hand be placed on the uterus its intense hardness powerfully shadows forth the pressure which must be exerted on the child within, and in like measure on its own tissue. Some have called this tetanus, especially when the pains are sudden, like the case just narrated. Unless relief is obtained by subduing

it either by sedatives as opium or chloroform inhalation, there is imminent danger of rupture; or by abstracting the child by the appropriate tractors. Now, secale may be guilty of producing this action, and therefore I say we should not give secale, if an obstacle exist or is expected, without having our instruments close by, in case of arrest. If this action be not excessively sudden, we may control it by the use of opium in moderate repeated doses, or still better, subcutaneously given. If they come on very suddenly the inhalation of chloroform is the best and promptest means of alleviating their severity.

NOTES ON HISTOLOGY.

(From Dr. Pye-Smith's Demonstrations of Practical Physiology.)

(Continued from page 140.)

A good English microscope costs from £7 to £12. Foreign ones are cheaper, and at least as good. Most of the instruments used in this class are by Beck*, Crouch,† or Baker,‡ but the best are usually by Hartnack §

First ascertain the flatness of the field, good illumination and absence of coloured fringes, and then judge of its magnifying power, definition and penetration rather by a histological object like a muscular fibre or blood-corpuscle, than by a diatom or podura-scale.

In anatomical work we use transmitted light. Bull's eye lenses, Lieberkuhns, and other apparatus for viewing opaque objects by reflected light are, therefore, practically useless.

A monocular microscope is in every way better than a binocular. The only advantage of the latter—saving fatigue—is better accomplished by learning to work either the right or the left eye with both open. This may be done by fixing a piece of paste board on the eyepiece, so as to form a kind of blinker for the eye which is not in use.

When using your microscope, first dust the mirror and adjust it until you have a clear and bright field. Then, if there are any specks in it, turn your eye-piece. If they move, they must be in one of its lenses. Wipe the eyeglass with dry soft and clean cloth (old cambric rag or silk is best) then look again. If the specks are still seen, unscrew the eye-glass and wipe both surfaces, and if they still remain wipe the field-glass inside and out in the same way. If, however, the specks do not turn with the eye-piece, they must be in the objective. The under object-glass ought not to be either wet or dusty, and if, after carefully wiping it, specks still remain, you must take the objective to the maker; for if you unscrew the lenses you will not be able to "centre" them accurately in putting them together again.‖

The instrument is now ready for use. The next thing is to prepare your object for it. Put in the middle of a glass-slip a drop of water (or salt solution, glycerine, &c.) and then place in this the smallest possible fragment of the substance you wish to examine. Tear it to pieces with needles under the water. Then, having carefully rubbed a cover-glass until it is perfectly clean and shining,¶ put down one edge of it first on the drop of water, and then let it gradually down, and gently press on it with a needle or any other dry and clean instrument. If the water does not reach the edge of the cover glass add a little with a glass rod, if it runs beyond it, soak up the excess with blotting-paper.

Air bubbles must either have been introduced with yout object, or show that the cover-glass was greasy or was carelessly put down. If large and few you may coax them our with your needle, or jog them out by a gentle blow with its butt end.

Now put the slip on the stage, taking care that both are perfectly dry, and focus slowly down to it. When in focus examine the object as to the following particulars:—

1. Its general shape.
2. Its size compared with a blood-disc.
3. Its outline
4. Internal markings. } Moving the fine adjustment.
5. Fracture, if broken at the ends.
6. Colour.

Next, draw it—however roughly—and note any peculiarities. This is of vast importance, not only as the best way of recording what you observe, but also because it is the only way of learning how to observe. A neutral tint reflector enables you to copy the exact size of the object, but you may do this very fairly by looking at the paper with one eye and the object with the other. By a little practice you can bring the image and your outline of it to coincide.

Lastly, add re-agents, and note their effects.

The following are the re-agents we have in ordinary use:—

1. Acetic acid. Clears connective tissues, makes nuclei and elastic fibres more distinct.
2. Potash. Makes horny epithelium transparent; softens most tissues.
3. Iodine. Stains transparent tissues; turns starch blue.
4. Ether. Dissolves fat.
5. Salt solution. Half per cent. of chloride of sodum dissolved in distilled water for putting up delicate, especially living, tissues, being of about the same sp. gr. as the plasma of the body.
6. Distilled water is itself a re-agent, being of lower sp.gr. than the plasma, and causes euosmosis, while syrup, being more dense than serum, acts in the opposite way.
7. Glycerine. For putting up thick sections. Also, either diluted to half or one-third its strength or undiluted, for permanent mounting.
8. Nitrate of silver. Stains the edges of or connect uniting epithelial cells, especially of endothelium.
9. Carmine. Stains too transparent objects, especially the nuclei and living protoplasm.

In examining granules, cells, &c., in liquid, take a small drop and dilute it, if necessary, with salt solution. A dozen of the elements show their structure better than the field full. Use a quarter objective, and then draw out the tube and put in it the deep eye-piece.

In examining the elements of solid tissues take a fragment just visible. Put it up in a drop of salt solution, water, or glycerine. After seeing them at rest, send a stream of water through by putting a drop at one side of the cover-glass and sucking the water up by blotting-paper on the other. As cells roll over in the stream you see both surfaces. Irrigate the slide with acetic acid, or other re-agent in the same way. Use high powers, as above.

In examining the composition of tissues and organs, cut sections. For this purpose some structures, as cartilage need no preparation. Others, as skin may be put between

* Late Smith and Beck, 31, Cornhill.
† 6, Barbican.
‡ 244, High Holborn.
§ 21, Place Dauphinn, Paris.
‖ Objectives which are intended to take to pieces—so-called combination lenses—are never good.
¶ Never touch any part of the cover glass. If you find them greasy, put them all together in liquor potassæ.

cork or carrot (or imbedded in gum, pitch, wax, paraffin, &c.) Others, again, as bone, must be softened by acids. And most must be hardened by immersion in alcohol or chromic acid solution.

In making sections, let the razor be heavy and keen. Keep it and the section wet with spirit or water. Cut as many sections as the blade will hold, wash them off into a watch-glass of water with a brush, select a good one, and put it in the drop of water on the slide with a brush, spreading it out flat and free from air bubbles.

Begin with a large, even section and a low objective, then choose a very thin, though smaller one, and examine it with the highest powers of your instrument.

The usual way of mounting is in glycerine. This must be diluted, or not according to the transparency of the specimen. Most tissues require to be stained, or they become too transparent with time.

Errata.—In last Saturday's issue, on page 139, read "Grew" instead of "Crew," "Leeuwenhock" instead of Leenwenhock" (bis), "Aselli" instead of "Ardle"; on page 140, read "Hartnack" instead of "Hartnach," and "stage" instead of "staff."

IDIOPATHIC ANÆMIA.

The discovery of Idiopathic Anæmia having been recently appropriated by two German physicians, Dr. Wilks, through the medium of the *British Medical Journal*, reminded the profession that this affection had been taught by Dr. Addison, who first observed it, as early as 1843, while he had himself published several fatal cases in the Guy's Hospital Reports for 1847-49.

Dr. Addison in his treatise on the Supra-renal Capsules, gives such a perfect description of Idiopathic Anæmia, that we are tempted to quote it *in extenso* before giving the report of the following case, which has recently died in the hospital:—

"For a long period, I had from time to time met with a very remarkable form of general anæmia, occuring without any discoverable cause whatever—cases in which there had been no previous loss of blood, no exhausting diarrhœa, no sclerosis, no purpura, no renal, splenic, miasmatic, glandular, strumous, or malignant disease. Accordingly, in speaking of this form in clinical lecture, I, perhaps with little less propriety, applied to it the term 'idiopathic', to distinguish it from cases in which there existed more or less evidence of some of the usual causes or concomitants of the anæmic state. The disease presented in every instance the same general character, pursued a similar course, and, with scarcely a single exception, was followed after a variable period by the same fatal result. It occurs in both sexes, generally, but not exclusively, beyond the middle period of life, and, so far as I at present know, chiefly in persons of a somewhat large and bulky frame, and with a strongly marked tendency to the formation of fat. It makes its approach in so slow and insidious a manner, that the patient can hardly fix a date to his earliest feelings of that languor which is shortly to become so extreme. The countenance gets pale, the whites of the eyes become pearly; the general frame becomes flabby rather than wasted; the pulse, perhaps, large, but remarkably soft and compressible, and occasionally with a slight jerk, especially under the slightest excitement; there is increasing indisposition to exertion, with an uncomfortable feeling of faintness or breathlessness on attempting it; the heart is readily made to palpitate; the whole surface of the body presents a blanched, smooth and waxy appearance; the lips, gums, and tongue seem bloodless, the flabbiness of the solids increases, the appetite fails, extreme languor and faintness supervene, breathlessness and palpitation being produced by the most trifling exertion or motion; some slight œdema is probably perceived about the ankles; the debility becomes extreme. The patient can no longer rise from his bed; the mind occasionally wanders; he falls into a prostrate and half torpid state, and at length expires. Nevertheless, to the very last, and after a sickness of perhaps several months' duration, the bulkiness of the general frame and theobesity often present a most striking contrast to the failure and exhaustion observable in every other respect. On examining the bodies of such patients after death, I have failed to discover any organic lesion that could properly or reasonably be assigned as an adequate cause of such serious consequences, etc."

IDIOPATHIC ANÆMIA—DEATH.

(Reported by Mr. Edgar Duke.)

J. K., æt. 52, admitted Dec. 23rd into Stephen Ward, under the care of Dr. Wilks.

Family History.—Good. Father died æt. 77, mother 90. Relatives healthy. Had gonorrhœa when a young man. Twenty years ago had acute rheumatism. Ten years ago was in Naaman Ward, under Mr. Cock, with urethral stricture, otherwise has had good health. Patient had been a signalman for twenty years, working in draughty boxes, and almost constantly on his feet. He has had a chronic cold in his head for years. Five or six months ago had a bad attack of diarrhœa, and was laid up in bed a week; getting well, he returned to work. Has been getting weaker daily since then, and gradually losing his appetite. For four months has had an unpleasant smell in the region of the bridge of his nose whenever he stoops down, this left him ten days ago. Has had a bad cough for two months, worse in the morning and a great deal of expectoration, occasionally tinged with blood. A month ago was too weak to go to work, and at the same time had fainting fits, whenever he took any exertion whatever. Has had pains in his back for three months. A month ago came to Dr. Pye-Smith's "out-patients." Whilst attending there the pains in his back left him, and his other symptoms were relieved; but for the last week has been losing his appetite rapidly, and becoming so much weaker that he was admitted yesterday.

On admission, Dec. 24.—Is a very anæmic yellowish-looking man. Skin dry. Nails filbert in shape and yellow in colour. Sclerotic pearly, sight good. Tongue furred. Bowels open. Lips and gums very anæmic. Liver. Dulness normal. Lungs. Resonant in front vesicular murmur normal. No cardiac dulness. Apex beats in epigastrium, almost to the right of xiphoid cartilage. Sounds clear. Venous murmur over each jugular. Urine. Sp. gr. 1010. No albumen nor sugar. Can only pass his water with difficulty, and makes only a small quantity at a time. Sometimes micturates twenty times in a night, and is unable to hold his water for any length of time. Legs and feet œdematous, especially the right. Patient is very weak, and takes very little nourishment. Full diet with beer. Ordered, tr. ferri perchlor dr j.

Dec. 29—Ordered ext. nucis vomicæ gr ½, pil. rher. co. gr iii, bis die, nocte maneque. Rep. mist.

Jan 3, 1875—Appetite bad. Cannot drink his beer. On microscopical examination of his blood, "the red corpuscles do not seem to be decreased; on addition of iodine, they become oval in outline; they become huddled together in bunches, but not into rouleaux.'

Jan. 10—Patient looks a little better, Low diet, chicken, wine ℥iv. omit beer.

Jan. 14—Feels sleepy. Urine, sp. gr. 1002.

Jan. 15—Has a little colour in his lips.

Jan. 18—In the same state. A distinct systolic bruit heard below xiphoid cartilage by pressing firmly with the stethoscope. Abdominal aorta may be plainly distinguished by pressing firmly with both hands.

Jan. 19—Passed all his water into his bed last night.

Jan. 20—Again passed his water into his bed during the night. Body covered with pediculi. Vomited some black matter on the bed clothes in the evening.

Jan. 21—Looks much worse, skin has a waxy appearance. Feels better. Sleeps well. Urine sp. gr. 1020. No albumen or sugar,

Jan. 22—Looks in the same state.

Jan. 23—Patient died this morning at 10.15 a.m.

P M.—Lungs healthy; a very large quantity of froth in the tubes; right lung œdematous, left slightly so, not so much as right.

Heart—11⅓oz, some fatty degeneration.

Liver—57oz., healthy; pyloric end of stomach much thickened, about ⅛in. thick.

Kidneys—13oz., healthy, though very pale and anæmic.

Spleen—4½oz., but contained several small caseous nodules.

There happens to be at the present time another case of idiopathic anæmia in the hospital—No. 5, Stephen Ward—which will well repay a visit from any one unacquainted with this serious disorder.

Physical Society.

At the meeting of the Physical Society held on Saturday, Feb. 8, a paper was read by Mr. Shadwell on the Treatment of Rheumatic Fever, of which the following is an abstract:—

After making some remarks on the frequency of complications in Acute Rheumatism, he said the next point to look at is the duration of the disease. This has been shown by Sir William Gull and Dr. Sutton to be—in males 13·1 days, in females 15·5 days, this being the average in 41 cases treated chiefly with mint water. We now come to the consideration of some of the various modes of treating Acute Rheumatism; the first which claims our attention is the alkaline, or method of neutralisation, this is spoken of in our text-books as being the most efficient in warding off cardiac complications, in relieving pain, and tranquilising the pulse. Of twenty cases admitted into this hospital without heart trouble, only nine recovered without complications, of the remaining eleven eight had endo-carditis, one double pleurisy with peri-carditis, and one was a case of hyper-pyrexia which terminated fatally, the urine having become alkaline two days previously. The average duration of the disease under this form of treatment was 21·1 days. The blister treatment, or method of elimination, has been advocated in this country by Dr. Herbert Davis. There is no doubt that by this treatment pain is greatly relieved in the majority of cases, but the influence on the pulse is not more marked than in other forms of treatment. The effect on the temperature is a point of interest; in six cases I found that there was a rise of about one degree after blisters had been applied, but in one case there was a slight reduction of temperature. With respect to the frequency of complications I am unable to give an opinion; but three cases, which were admitted without cardiac mischief, went out free from any complication, and another was a case of hyper-pyrexia. The Actœa Racemosa has been given in a few cases, and with a very fair result; in these cases there were no complications, and the duration of the disease was 10·5 days. The treatment of rheumatism by lemon juice was recommended, and largely practised by Dr. Owen Rees, of this hospital. If we carefully examine those cases which have been treated on this plan we shall find that the results have been on the whole satisfactory, that is, out of thirty cases twenty-nine recovered without complications, the remaining one was a patient somewhat advanced in years, who died of pulmonary embolism, the clot having been carried from the right femoral vein. The average duration of the disease in these case was 8·5 days. Ergot has been given with the object of reducing inflammation and lowering the temperature, but this effect has not been well-marked or long-continued. Of ten cases treated on this principle the following was the result:—in three there were heart complications, one was a case of hyper-pyrexia, which terminated fatally, the remaining six did well. The average duration of the disease in these cases was 12·4 days. The tonic form of treatment is the last to which I shall direct your attention. Under this head are included those cases which were treated with iron and quinine, either separately or in combination. This appears to be the most rational plan of treating a disease, in which there is more or less prostration or depression, and which runs its course in somewhat under 20 days. Of twenty cases treated on this plan, eighteen recovered without complications; in one the result was doubtful, and in the other alkalies had been taken for seven days before commencing the tonic treatment, and there was inflammation of the endo-cardium. The duration of the disease in these cases was 10·7 days. Mineral acids have been given in a sufficient number of cases to show that persons suffering from this disease can recover without having the poison which is circulating in the blood neutralised by large quantities of alkalies. Bedding and diet are perhaps the two most important points in the treatment of Acute Rheumatism. Patients should be kept warm and well protected from draughts. The diet should consist of milk and farinaceous food until they are free from pain and the temperature normal. The bowels should be regularly kept open, and, as a rule, it will be found desirable to administer an opiate at bed-time. The per-centage of complete recovery under the various kinds of treatment is as follows:—Alkaline, 45·0 per cent.; ergot, 60·0 per cent.; tonic, 90·0 per cent.; lemon juice, 96·6 per cent.

Mr. WATERHOUSE said that all the forms of treatment except one seemed to be based upon the principle of quieting the nervous system and lowering the pulse. If these were the true guide there were plenty of means by which it could be accomplished. We had a number of vascular sedatives, and one would probably be as good as another. He, however, thought they must seek for some other effects, the chief being the liability to heart mischief. He thought if patients recovering from the acute fever were allowed to rest in bed for twelve or eighteen months, the liability to heart disease might be greatly lessened or altogether prevented. The most rational treatment mentioned in the paper was the tonic treatment.

Mr. FRY was surprised to hear from Mr. Shadwell's statistics that under the alkaline treatment the disease lasted longer. Dr. Gull had said that if the urine became alkaline before any complication arose, none would arise subsequently. Dr. Murchison, of St. Thomas's, very much ran down the treatment of acute pericarditis or pleurisy by blisters, as it would rather tend to increase than subdue the inflammation; but in chronic cases, he said, this plan was most useful. He (Dr. Murchison) had been giving Veratrum viride in doses of m xv of the tincture.

Mr. COLEY remarked on the uncertainty of the alkaline mode of treatment, and said the experience of all the physicians in Europe was not sufficient to give a definite opinion upon it. It seemed to have been simply started with the view of rectifying the acidity of the urine. He was inclined to think himself that the best mode of treatment was the expectant, continuing the treatment so long as there was nothing arising to give an obvious indication for anything else, *e.g.*, if hyperpyrexia supervened, they must have recourse to vascular sedatives and cold baths. He did not think that Mr. Waterhouse's plan of keeping the patient quiet in bed for a year or two was practicable.

Mr. SYMONDS said it seemed to him that rheumatism was a disease that ran a definite course, and no matter what the treatment was, the actual pain and suffering could not be diminished. Allowing this, the great object seemed to be

so to treat the disease as to prevent the terrible complications. They might put the patients under the influence of alkalies, *i.e*, until the urine was alkaline, but they did not thereby cease to be liable to cardiac complications, so long as fresh joints were affected. Looking to the facts of the *high temperature, loss of appetite, and great depression of* the patient, giving alkalies would only lessen his strength still more, and so make him less able to support a long convalescence, therefore the best treatment would be the tonic. As to blistering the joints, patients seemed to like the plan; but he did not see how it could prevent cardiac complications, unless they supposed it attracted the disease away from the centre, in the same way as in a case of small pox, the pustules gathered more thickly round a blistered part.

Mr. Green, in speaking of treatment of hyperpyrexia, said that the cold baths were most frequently adopted in this hospital. He described four such cases which he had seen, three dying and one recovering. Regarding the heart as a joint, he thought the blister treatment was imperfect, because they did not blister the heart at the same time as the other joints. Rheumatism showed its metastatic character markedly by the occasional occurrence of pleurisy. Mr. Shadwell had not mentioned aconite. It was often effectual in reducing the temperature.

Mr. Paul did not think Mr. Green's remarks gave them so favourable an impression of the cold bath treatment as it deserved. In all the cases there was certain death if left alone, and, therefore, one recovering out of four was very good indeed. After the patient is taken out of the bath the temperature runs down two or three degrees more, and in one case rather severe collapse was thus induced by keeping him in the bath too long. Most of Mr. Shadwell's forms of treatment were those given on some theory of the disease, which seemed to be a mistake, as we knew so very little of its natural history. We had no power whatever of cutting short any complications, therefore the only thing remaining was to cut the disease itself short, and relieve its most prominent symptoms, and for this he thought lemon juice preferable to tonics.

The usual vote of thanks, proposed by Mr. Fry and seconded by Mr. Waterhouse, having been carried unanimously, the meeting adjourned.

JUNIOR GUYITE CLUB.

This club which has for its object the bringing together annually old Guy's men is open to students in their third, fourth, and fifth years. Gentlemen wishing to join are requested to send in their names to any member of the committee before Tuesday, February 16, admission to take place by ballot, black balls from one-fourth the number to exclude a gentleman.

A general meeting of the original twenty members—Messrs. Amphlett, G. Bond, Burton, A. Baker, A. L. Bowen, Cock, H. Cotton, H. Duke, T. Duke, G. Davis, P. Gilbert, Maclean, C. J. C. Mitchell, Morgan, H. M. Powell, J. Rendall, Rudd, J. B. Richardson, Stevenson, Wallis—will be held on Tuesday, February 16th, in the room facing the Library, to elect the honorary secretary, other officers of the club, and several new members.

Committee (*pro tem.*)
Third Year—Messrs. Gilbert and T. Duke.
Fourth Year—Messrs. Cock and Burton,
Fifth Year—Messrs. Rendall and Powell.

Correspondence.

[We do not hold ourselves responsible for opinions expressed by our correspondents.]

THE BAVARIAN SPLINT.

To the Editors.

Sir,—As your excellent account of "How to make a Bavarian Splint" seems to cause a good deal of interest among the students at the hospital, will you allow me to say a few words on the subject?

As regards the interior of the splint, I have found it useful to apply a common calico bandage round the limb before the inner layer of flannel is put on, because it forms a sort of pad, while the splint is hardening, and also prevents the splint sticking to the hair, which causes a good deal of pain when it is first taken off, if any of the gum and chalk mixture has escaped through the meshes of the flannel, as sometimes occurs.

In your last week's issue I see a letter from Mr. E. J. Hicks; he says, in making a Bavarian splint for the hip, the great trouble is to prevent creasing in the "fork" of the leg; by fork, I presume Mr. Hicks means the groin, and he suggests that cardboard moistened in boiling water should be placed there, but surely moistened cardboard is soft, and how can anything soft keep something else soft from creasing? I suppose Mr. Hicks meant to say that the cardboard should be adapted and hardened before the splint is put on. The way I have managed to prevent creasing is to lay the patient on the sound side and prop his shoulder up with pillows, then to place the leg of the side affected in a straight line with the body on a pillow and fix it with sandbags and flex the knee of the other side beneath it, and then apply the splint. It is not such an uncomfortable position as might be expected, and allows free access of air to almost the whole of the splint, and thus facilitates its drying.

I have not yet seen anything stated about a Bavarian splint being applied for a fractured patella. I saw one lately applied by a dresser at the hospital to a case of six weeks' standing. It was made in two pieces above and below, the patella reaching from the upper third of the thigh to the middle of the leg, notches being cut to fit accurately the fragments and eyelet-holes were let in and the two pieces laced tightly together, it answered very fairly; but another is about to be made with a thin piece of iron eight inches long and two inches broad, let in between the two layers of the splint before being hardened, the centre of the iron to be placed at the posterior aspect of the knee-joint.

Another point I would direct your attention to. Cannot something be added to the gum and chalk mixture to cause it to dry more quickly, the silicate of potash being too expensive and plaster of Paris too heavy to render their use general at the hospital?—Yours, &c.,

A Surgeon's Dresser.

A SEA DREAM.

I am not much given to writing. I love to read better than to write, to listen rather than to speak. This may be due to the inherent laziness of my nature, or to selfishness; for it is better to give than to receive. Yet, it may be that a natural modesty warns me not to be pharisaical. Whenever I invent or discover anything new, it shall be given to the world.

I am frequently reminded of this, that "Reading maketh a full man; writing, an exact man; speaking, a ready man,"* qualified by Solomon's advice,—"And further, by these, my son, be admonished; of making many books, there is no end; and much study is a weariness of the flesh"†; as well as by Burton's declamation against excess of literature.

Yet I am glad to see that Guy's is able to support a Hospital Gazette. Floreat Guyensis!

Last night I dreamed a crowd of players passed before me. Among them was a child that attracted my attention, for was not her left ear replaced by a wrist and hand, that seemed not only to collect sound, but also to sieze upon and grapple it?

Then, indeed, I saw that the ear is the analogue of the hand, and that one is as much an organ of prehension as the other. Then, also, I determined to get a copy of this most peculiar and instructive condition, and, to that end, resolved to join their party. In moving, I awoke.

Enquiring within myself the possible origin of such a waking thought; did I not the other night use my hand in listening to the captain; and that very morning discuss with the purser analogy and homology in the webs of human and duck's feet?

Do I not believe I am on the verge of a great discovery? Was I not amused with the fantastic procession of the "Transit of Venus"‡; and does not my literary amusement now consist of Ruskin's Oxford Lectures, and Mrs. Gaskell's "Wives and Daughters?"

Psittacus.

Dec. 30, 1874.

* Bacon's "Advancement of Learning,"
† Ecclesiastes ch. xii. v. 12.
‡ "Punch's Charivari," Dec. 17, 1874.

Sports.

FOOTBALL.

Inter-Hospital Challenge Cup.

The first round of ties for this cup was played at the Oval last week. The first match was on Monday, between University College Hospital and St. Thomas's, the former just managing to win by one touch down.

The next day Bart's. played St. Mary's, and won by three tries and seven touchdowns.

On Thursday, the 4th, Guy's played King's, and were easy winners by two goals. three tries, and seven touchdowns to nothing.

The second round of ties was commenced on Monday last when Middlesex opposed Guy's. The latter had it all their own way, winning by two goals, seven tries, and ten touchdowns to nothing.

On Wednesday, the 10th, University beat King's by three goals, two tries, and touchdowns.

Yesterday, St. George's were to play Bart's., thus bringing the second ties to a conclusion. The winning team of the latter will be left with Guy's and University to play off the last two matches next week. One of the three hospitals thus left in must draw a bye, and will then play the concluding match with the winner of the other two. A notice will be posted in the Colonnade on Monday, giving particulars of the days on which the last two matches will be played.

Marriage.—On the 3rd inst., at St. Mary's Church, Aspeden, William Hamerton Jalland, F.R.C.S., of York, to Ellen Maria, second daughter of George Mickley, Esq., of Buntingford.

The Wards.

MEDICAL.

The following Cases were admitted between Feb. 4 and Feb. 11:—

Addison—8—Chorea. 8—Chorea. 9—Diabetes. 18—Catarrh. 25—Hysterical paraplegia. 30—Eczema. 32—Chronic pyæmia, after scarlet fever. 39—Pleurodynia.

Philip—3—Mitral disease—constriction (?). 5—Mitral disease—bronchitis 23—Rheumatic fever—pericarditis.

Bright—3—Hysteria. 16—Chronic rheumatic arthritis. 21—Mitral regurgitation. 22—Mitral regurgitation.

Stephen—11—Bronchitis. 18—Convalescent from typhoid (?) 19—Bronchitis. 38—Acute rheumatism. 40—Congenital heart disease. 50—Syphilis.

Mary—4—Syphilis. 15—Acute rheumatism. 21—Pelvic cellulitis.

John—1—Acute tuberculosis—death. 4—Typhoid fever. 7—Pleuritis effusion. 13—Morbus cordis. 16—Lardaceous disease (?)

Miriam—20—Acute rheumatism.

SURGICAL.

The following cases were admitted between Feb. 4 and Feb. 11:—

Accident—Frectured fibula. Fractured jaw. Burn. Lacerated wound of thumb. Fracture of os calcis. Concussion. Fractured patella. Old subcoracoid dislocation of humerus.

Job—Axillary abscess. Necrosis of tarsus. Anal fistula. Cicatricial stricture.

Lydia—Compression (?) Specific sores. Fractured femur.

The Presidents of the Physical Society acknowledge, with thanks, the following honorary subscriptions towards the support of the "Gazette":—Dr Goodhart, £1 1s; and Mr C. H. Golding Bird, £1 1s.

Also the receipt of Subscriptions due from Messrs Alabone, S. Atherton, A. Aspland, Aldersey, W. H. Booth, Berry, Ball, Hugh Bennett, Butler, R. M. Craven, M. A. Collins, H. A. Collins, Collier, Cookson, Cockell, Couling, G. Davis, E. Domvill, Ewart, E. Field, A. M. French, Fawsitt, J. L. Growse, Graham, Gillingham, W. C. Hills, Hodson, Hawser, Joyce, J. E. Jones, W. H. Lamb, W. P. Mallam, J. Morgan, A. G. Medwin, A. G. Mickley, Manser, J. G. Murrell, Mason, Manby, Moore, R. F. Palmer, G. Paddon, C. Palmer, Ransford, Rogers, Reid, Roots, Rossiter, E. Sunderland, Simon, Tomlin, C. S. Ticehurst, T. O. Walker.

Received.—The Medical Record—The Sanitary Record—The Medical Press and Circular—and a Communication from Mr. Todd.

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Guy's

Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 20. SATURDAY FEBRUARY 20, 1875 TWOPENCE

IN an age when there are so many subjects for thought and investigation, it is no wonder that men should be found who have but one idea. Absorbed in that which forms their chief delight, their one topic soon engages all their thoughts. Thus, it is easy to see how so many things are carried to extremes, and that which in moderation would demand universal attention becomes so abused as to be forgotten when it should be remembered. A man with one idea is consequently a very unfortunate individual, but much more so is he whose only idea is in itself bad.

We imagine that there are few, if any, of those well-trained minds which form the higher ranks of the Medical Profession, that would be so carried away with one idea as to maintain scientific research irrespective of its bearing on the living subjects of their experiments. It cannot be denied that Vivisection has done much to enlighten us, and has afforded us much information which has enabled us to alleviate pain and prolong life. It would, indeed, be almost impossible to trace out entirely what a marvellous amount of light this means of investigation has shed on our knowledge of Pathology and the Treatment of Disease. Many branches of these departments seem to be at the present time—as the insect in its "pupa" state—more obscure now than we had formerly thought them to be, but evidently being prepared for some greater manifestation of what they are; and to this change Vivisection is a great contributor. It is a mode of discovery which, from the suffering it oftentimes occasions, needs to be confided to skilful hands, lest mere curiosity to see certain physiological facts exemplified should induce many to practice it without really benefitting either themselves or others. It is this mode of proceeding which has brought opprobrium on the whole system of experimenting on the living subject. Such dabbling in Science is much to be deprecated.

We draw attention to this topic because it is now the subject of inquiry by those who claim to be the friends of both the lower and higher animals. These individuals are, however, considerably inclined to be men of one idea. The name of the society which has originated this mode might, indeed, commend itself, were it not evident that those who constitute its members had carried their main idea to such an extreme as to forget to aid in alleviating the sufferings of the "*higher* animals." They have ridden their hobby to death, and, though possessing a good principle to start with, they have lost sight of its true bearing, and too frequently aid that which they profess to discourage. Increase of power has blinded them at least in the matter of Vivisection, the evils of which they have magnified, and the benefits of which they have ignored.

It has been alleged that painful experiments have been often performed on live animals for the purpose of class instruction. Surely this is a *very* exceptional practice and the statement must have arisen from those who are unaware of the physiological conditions which give rise to pain, and who know nothing of the subject of reflex action

With regard to the performance of painful operations, it is, perhaps, a fortunate thing that the struggles of the animal compel the operator to employ anæsthetics, unless he be performing such experiments on the nervous system as necessitate the existence of sensation, which are comparatively rare. More pain is frequently involved in the administration of the anæsthetic than in many of the operations which have been so objected to. Among those operations which have been performed for the instruction of the Guy's students, we do not remember seeing any which involved an unnecessary amount of pain, anæsthetics being employed whenever practicable. We know, therefore, that the inspectors who have received permission to witness some of these will not be able to carry away an evil report concerning our school unless they have unlimited powers of exaggeration.

We would desire it to be distinctly understood, therefore, that while we warmly maintain that Vivisection is not only a legitimate, but a necessary means of research, we do not give our support to uncalled-for cruelty on the part of the students of Physiology and Pathology; but that while those who are in a position to carry out their investigations to some result, may thus proceed, it is not the business of all those who wish to alleviate suffering in their fellow-creatures to dabble in Vivisection.

FURTHER on we publish a short notice, which has been sent us, of a recent meeting among the students with the object of forming a Guyite Club. Such meetings have taken place two or three times within the last few years, each having resulted in a lamentable failure, and for a very obvious reason: namely, that every one desirous of becoming a member treated the matter as though he were about to give an annual dinner, to which he only intended to invite his particular friends; consequently, each individual black-balled all who had not the honour to be intimate with him; or he withdrew at once because the president, or the secretary, or the committee did not happen to be quite to his taste. So marked has the selfishness of party-spirit been in the attempts above alluded to, that we are constrained to warn the Junior Guyite Club, by recalling them as sad examples by which to profit, for we take the greatest interest in the success of this club; and, if rumour speak truly, our warning is not inopportune, for, strange as it seems, it appears true that a little clique of enemies have exerted their power, and prevented from joining his fellow-students at the annual dinner, one, who has well been described at a recent "introductory" in the following words:—(as in the story of Horatius). "When all our men but one were wounded, he who survived unhurt redeemed for us the day single-handed"; while there has been a general disappointment created by a very fierce black-balling. However, the next meeting will be larger, and the committee will probably have the good sense to require a greater number of black balls to reject a proposed member. We are of opinion that the formation of such a club should be conducted upon the most generous principles, that private feeling should not be studied in the least, and that those only should be rejected, who, being in a considerable minority, have no right to share the privileges of Guy's men. In this way only can a large and permanent club be established, and men of the years indicated in the notice have a right to expect no less opportunity of joining the club than this. Bear in mind we are speaking of a "Guyite" Club. If the meeting, which took place last Tuesday, had only for its object the formation of a private club amongst the Officers and their friends, then they had every right to blackball their fellow-students upon private grounds; but it was with a mistaken presumption that they named it the Junior Guyite Club. As a private club we have no interest in it; but, if it is to be a Guyite Club, we wish it every success, and hope that a fair field, uninfluenced by private animosities, will be given to every eligible Guy's man.

A STUDENT'S NOTES OF

Lectures on Midwifery.

By J. Braxton Hicks, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

Lecture XV.

The continuous action, or, as it has been called trismus uteri, I have already alluded to; it is controlled best by the small doses of opium before mentioned, and by chloral hydrate or chloroform. If it does yield, then traction is necessary; there is no good, but rather harm in waiting. Generally this trismus uteri arises out of the natural pains, but sometimes the rythmical action is never set up; continuous action begins and gradually increases, never ceasing till the child dies, and decomposes; and the mother, after five or six days of extreme distress, dies, often sudden collapse intervening upon the other symptoms. Some very remarkable cases of this kind have occurred to me. In a case of placenta previa at the seventh month there had been hæmorrhage, and to arrest it and set up labour, the placenta had been detached all round the os uteri, as far as the finger could reach, as suggested by Dr. Barnes. It was expected that labour pains would arise, but they did not; the uterus became hard and contracted. On the third day no progress having occurred, the medical attendants were anxious to start labour, and to this end dilated up the cervix by the elastic bags. The os uteri was thus partly dilated, but still without any advance of labour. Next day attempts were made to bring down the child, but without success, as it could not be well seized. The fifth day the arm came down, and every effort was made to turn the child, or to draw it down, but without result; the uterus, like a bomb shell, continued in the same condition. Towards the end of the fifth day she began to fall into an anxious state; symptoms of exhaustion arose, and with that a rapid distention of the abdomen. I was asked to see her. I found the abdomen hard and tympanitic, but on careful investigation found it was the uterus which was distended and resonant throughout, not tympanitis. I placed the woman under chloroform and ether, and attempted to alter the position of the child. This was utterly impossible.

Rigid, as solid as papier-maché, remained the arm projecting into the vagina. I then passed the perforator into the chest and abdomen, when a violent rush of offensive gas escaped from the fœtus, which as suddenly shrank, leaving the uterus empty but not flabby, nor contracted but still in the same bomb-shell like condition. However, after a little time, by external manipulation, I was able to turn the fœtus so as to draw down a leg, and withdrew the body—the head followed, but with much difficulty. However, steady firm traction succeeded. The placenta followed shortly without hæmorrhage. The patient, however, sank two hours after.

These cases are rare; but are excellent traps for the ignorant or unwary practitioner, and always difficult for the skilled, such as the gentlemen in attendance on this case.

But besides the states of excess just mentioned, there are irritable conditions of the uterus, which very much interfere with the well-doing of the labour. Short, flashing pains, with variable intervals, generally found in an excitable, feeble temperament, and liable quickly to run into continuous action. It is your part to find out what circumstances have assisted to bring forth this state. Often it is the state of the bowels, of the mind, or some extraneous influence. It is more frequent in the first stage, but by no means confined to it. Sometimes it arises from moving about too early, from want of sleep, from new attendants. It will be your duty to explore the cause, and to remedy it as far as practicable. It is always a good plan if it be early in labour to give an aperient or enema, if later on small doses of opiates, hydrate of chloral, a slight inhalation of chloroform. Soothe the nervous system, which is, of course, at fault. However, common sense will here assist you, and, if you think it is owing to your own presence as a new attendant, it will often help much if you retire from the room till you are really required. However these points must be left to your judgment and tact.

There is another variation from normal uterine action, which is apt to be mistaken for a very formidable event. I mean sudden cessation of all pains. I remember many years since to have seen a very marked case. It was a premature labour of the seventh month. The head had arrived at the perinæum with good pains; all at once they went off; as there followed no untoward symptoms, I was not anxious, and it being late in the evening I laid down to rest. After a good night of twelve hours, I was suddenly summoned, and found a pain, the first, had just come on. The child was immediately born.

The condition for which it may be mistaken is the cessation of pains consequent on rupture of uterus. For instance, a lady had been in labour (her fourth) and the head had descended to the perinæum readily, all things apparently going on most naturally, and it seemed only to require one pain for completion, when the pains subsided, without any particular complaint on the part of the patient. However, as they did not return for four or six hours, and as the pulse gradually rose and pain was complained of, her medical man was anxious and sent for me. I found a rent extending through the upper vagina, and running high up the anterior uterine wall. By that time her pulse was 120, but it had not been so from the first. Such a case imitates much both the rapid supervention of continuous action and also the simple cessation just now alluded to. If the hand be placed over the uterus, its rigidity or flaccidity will be readily made out. With rupture it is flaccid, not rigid. With simple cessation it is also flaccid, not rigid. Therefore we have only further to distinguish these two. Almost invariably the pulse will tell it, it is extremely rare not to find the pulse rapid, with collapse, more or less, but these failing to be present, at least in the early movements after rupture, we generally find a trickling of blood from the vagina, and expression of anxiety in the patient's face. Yet, of course, these may be absent in a single case. In most cases the distress of the patient and collapse follows closely the occurrence of lesion, and I think a careful examination of all the symptoms will lead you to distinguish these three conditions. There are other symptoms which follow rupture of the uterus, these you will hear when we come to the consideration of that calamity.

I have thus endeavoured, though not exhaustively, to point out some of the errors of uterine action. The subject is important because it deals with the motor force of labour. Indeed the study of the habits of the uterus will always repay you well. Its curious mode of contracting, its various shape, its adaptation to variously-shaped contents, and its great power, should be well known to you. I may instance an example where this knowledge was of excellent service. A woman, having a prolapsus uteri, was given a vaginal stem-pessary: after a few days this pessary entered the os, and went up to the fundus. The medical attendant was for a time puzzled how to act. However, he reflected that it could only have entered slowly and by the amœboid habits of the uterus; he thought it might be withdrawn the same way. He therefore attached an elastic cord to the portion in the vagina, tying the other end to bedpost, keeping up thus a constant traction. He was pleased to find by the morning the pessary had been extracted. The same knowledge will, in difficult turning especially, produce equally satisfactory results.

JUNIOR GUYITE CLUB.

The remarkable success which has attended the formation of the above club, completely justifies the course adopted by those who undertook the preliminary arrangements. At a meeting of the twenty original members held on Feb. 16, the following gentlemen were elected office-bearers for the ensuing year:—

President, Mr. H. M. Powell.

Secretary, Mr. L. H. Stevenson.

Committee.

Fifth Year—Messrs. Duke, Rendall, and Rudd.
Fourth Year—Messrs. Amphlett, Burton, and Cock.
Third Year—Messrs. Gilbert, Maclean, and Wallis.

A ballot having taken place, the following gentlemen were elected members of the club:—Messrs. Brock, T. Brown, Beale, J. Bell, H. A. Collins, Day, E. Duke, Fry, Finch, Ferrier, Foster, C. E. Green, Ingram, Lovett, Lacy, Mount, Mutch, Newman, Paul, Perry, D. D. Roberts, R. C. Richards, Romano, Simon, Sangster, Travers, A. M. Turner, Wells, and Welchman.

The meeting then adjourned to March 2. Gentlemen who desire to become members of the club are requested to communicate with a member of the committee before the 28th inst., they will then be ballotted for at the next general meeting.

SOME THOUGHTS ON SYPHILITIC MONOMANIA.

That "every third woman in London was guilty of baby murder," was a whilom famous saying attributed to a celebrated coroner. That "every other man in London is ruptured" was the saying of a not less celebrated surgeon. That "the force of the beat of the heart is 5oz., was the mathematically-formed opinion of a noted physiologist. That "the force of the beat of the heart is 180,000lbs., was the conclusion of an equally renowned physiologist and physisist. These statements, wild and weird though they be, are paralleled in our own day by the alarming cries about the spread of syphilis among civilized people, as uttered by surgeons and physicians, with a craze in favour of syphilis. Let certain men resolve to work at syphilis, and, as surely as the night follows the day, so surely will the large proportion of these enquirers become intensely biased in favour of syphilis. Every disease, every fracture even, will, in their opinions, be complicated by syphilis. Events, the most remote and improbable, will be changed to venereal affection. Said an old eastern monarch, "half the evil in my kingdom is caused by women." Our syphilis-loving doctors re-echo the Oriental's cry. That syphilis is "the key-note of all pathology," is the solemnly repeated verdict of a high American authority. In England the same thing obtains; there is no disease which, by some writer or other, has not been laid to the charge of syphilis. One believes that every case of iritis has at least a taint of syphilis." A second is assured that scrofula and rickets in children are inherited syphilis. A third thinks every miscarriage is due to it. A fourth that all phthisis is the direct result of the same poison. A fifth gives anti-syphilitic remedies in every case in which he fails to make a diagnosis, should the patient recover, his worthless opinion is confirmed—the number of cases he sees is alarming. In fact, we might go through the nomenclature of diseases. The devout Mohamedan exclaims, "there is but one God, Alhah is his name." Syphilis worshippers shape it thus; "there is but one disease, Syphilis is its name."

Laudatory chapters have been written on the scientific uses of the imagination, and loud shouts of triumph have rent the air when some master-mind, by his mighty weapon, has made some grand discovery. Great blessings may be abused, and be changed into fearful curses. Imagination untrammelled by logic, unarmed and unchecked by solid facts, will lead men on and on till they lose themselves in some bottomless pit. It would seem that on syphilis most enquirers have let their imaginations run riot; unarmed by the rude blasts of "brute facts" their imaginations have grown and grown, till medical literature and knowledge are well nigh choked by the pestilent weed. The direct curse which afflicts the progress of Medicine, the source of incalculable errors is this self-same unchecked imagination. If enquirers would subject their theories to rigid analysis, carefully sifting out what rests on no foundations, how mightily would Medicine progress, for error begets error, and error must be uprooted and displaced by truth ere real progress can be made.

In the *Birmingham Medical Review* for Jan., 1875, is a review of an address by the celebrated United States' surgeon, Dr. Gross, on "Syphilis in its relation to the Natural Health." The reviewer praises the address most highly, inserts its chief features, and, without a word of remonstrance, recommends it to all medical men. The statements in it are truly startling; but, if possible, more startling still is the fact that the reviewer utters no contradiction, but apparently swallows them most greedily.

The following are a few excerpts from Dr. Gross's work. He believes in "the propagation of syphilis by kissing," and asserts that he "has seen a number of instances." By English writers chancres on the lips are always attributed to libidinous sexual practices. He believes that "inhabitants of tropical regions of the world seem to be more liable to it and to suffer from it in a greater degree than do the people of colder and more northern regions." He says that formerly at times it spread like an epidemic and assumed a pestilent character. Turning to discuss its prevalence in the United States, he announces the impossibility of obtaining accurate data, but continues thus—"It may, however, be assumed that it is of gigantic proportions, that it exists in many of the best and noblest families of the land, that since the establishment of railway travel it has penetrated every rural district, that it is slowly but surely undermining the very fountains of life in every direction, sowing the seeds of death among our people, and gradually deteriorating the national health. Out of a population of 40,000,000, the present number of inhabitants in this country (U.S.), it is safe to assert that 2,000,000 are at this moment affected with the syphilitic virus." Were it not for the limiting phrase, "it may, however, be assumed," we should believe that Sodom and Gomorrah were holy places relatively to the United States. Certainly we believe that in those towns no such appalling wickedness existed as in New York and Philadelphia, where of "children under five years of age, 80 per cent. die of inherited syphilis." This statement of Dr. Henry's obtains the patronage of Dr. Gross's name and of the Birmingham reviewer. Our verdict may be expressed in one word—Nonsense.

Dr. Gross founds many of his proportions on English data, but these data are simply absurd and inaccurate. He says in the French army in 1862 there were 11,000 cases in active force of 300,000 men, and in the British army during the same period the proportion of cases was still greater. Dr. Gross reasons from such data as these that two millions of his fellow-countrymen are syphilised. He forgets that soldiers are notorious as sufferers from syphilis, that they are a wholly peculiar set of men, living under circumstances most favourable to the increase of syphilis.

Next, Dr. Gross takes some statistics from London hospitals; but it would be most interesting to know where he got them. Here are some—of 6,000 out-patients at Bart.'s, nearly one-half are said to labour from some venereal affection. Guy's men will be startled on learning that at their hospital "25,000 cases of a similar character are annually prescribed for."

Further, it is stated that at the Royal Free Hospital they "amount to the frightful number of 42,705, or 117 cases on an average a day." "At the Lock 200 out-patients daily, and at St. Thomas's Hospital one-half are similarly affected." In other metropolitan charities of the out-patients they vary from one-eighth to four-fifths daily. Our readers will perhaps kindly bear in mind that these arguments are adduced not by some obscure unlearned fanatic, but by the acknowledged head of American surgeons, the surgeon whom it delighted the University of Oxford to honour for his great attainments.

We remembered having read somewhere that Sir Isaac Newton expected to be held in high honour and everlasting renown, not for the grand and mighty discoveries which have gained him so lofty a position, but for his interpreta-

tion of the Book of Revelation, and his unravellings of unintelligible prophecies. We wonder whether the learned Dr. Gross expects to become more famous for his "assumptions" on syphilis and its statistics.

But a few more extracts, and we will conclude. He thinks there are 400,000 harlots in Great Britain, of whom 15-20 per cent. are infected." How wicked must be the people of the United States, where 5 per cent. of all the population suffer. He "supposes that the deaths from remote consequences are enormous." "The Sandwich Islands are in danger of being depopulated by it. Dr. John G. Brooks says that in less than a century the population has been decreased 75 per cent. by it." If our readers have easily swallowed this statement we will cap it by one of our own. Far over the seas, to the south of Australia is an island, yclept Tasmania: we introduced venereal affections there about fifty years ago, and now only one poor old aboriginal woman remains. To the east of this island are three others—New Zealand; here, too, venereal affections were introduced about forty years ago—the native population is diminished by 75 per cent. Probably when sixty more years shall have glided by, less fortunate than the Kanakas, they will all have passed away. In our new colony, Fiji, venereal affections have been introduced; there, too, the race will speedily disappear.

One last quotation from Dr. Gross. "After these appalling figures, can we wonder at the enormous rate of infantile mortality which pervades London and other large cities, both of the Old and the New World? Like apples which rot upon the tree before they are ripe, the children of these infected persons drop dead from their mother's womb, or if they are alive they are sure to perish soon after birth."

He quotes cases of women suffering from a number of miscarriages, due, as he supposes, to syphilis; but naïvely and truthfully adds that their social position was so high, he did not dare to ask the question.

Dr. Gross's London statistics, quoted approvingly by the Birmingham reviewer, are monstrously curious. In common with others determined to find syphilis, he uses that term apparently as a synonym for venereal affection of all kinds. At Barts.'s he quotes 6,000 out-patients. What has become of the remaining trifle of 100,000 who attend there? The average annual number of patients attending the Royal Free is somewhere between 40,000 and 45,000. Dr. Gross and the reviewer believe that they all suffer from venereal affection. In place of 50 daily treated at the *Dreadnought* we find a total number of 35,000 patients instead of the 18,000 it should be. The 200 who attend daily at the Lock Hospital may be similarly cut down. For some of these outrageous statements, Dr. Gross, a stranger, may be pardoned; but what shall be said of an English surgeon who approvingly quotes statistics so glaringly incorrect, merely to bolster up a pet theory.

Marriage.—On Feb. 17, at Blackheath Hill, Henry Francis Eastall, M.R.C.S. and L.S.A., to Ellen Elizabeth, youngest daughter of Thomas Deering, Esq., Greenwich.

At a meeting of the Physical Society this evening, Mr. Symonds will read a paper entitled "Some notes on the symptoms of Rheumatic Fever.

We hope members of the Physical Society have not forgotten that a prize will be given at the end of the winter session for the best essay on "Alcohol as Food, Drug, and Poison." Essays must be sent to the Librarian on or before March 1st.

Sports.

FOOTBALL.

As the First Fifteen unfortunately had no match arranged for to-day, a pick-up was made last Wednesday in order that the men might keep in practice for the final match for the championship next Thursday.

Nearly all the First Fifteen turned up on Blackheath at the time appointed, and were pitted against twenty-five others, who, with praiseworthy zeal, went down at a very short notice to make a game. A very pleasant game resulted, and at the close of an hour and three-quarters the fifteen were hailed victorious by 2 goals (one of them a drop by Pearson), 4 tries from runs in, a try from a fair catch by Welchman, a poster dropped by Pearson, and 3 touchdowns to nothing, unless we except a drop at goal by Scott which failed. To do them justice, however, the twenty-five played up very pluckily, especially during the first half-time, but after that the superior weight and strength of the Fifteen, aided by their good back play gave them much the advantage.

The Fifteen seemed to be in very good condition, and will certainly make a good fight next Thursday.

The back play of Pearson was remarkably fine, his long and straight dropping being most effective; we cannot help thinking that he too often attempts to run when he ought to kick, but there can be no doubt that he is altogether one of the finest backs in England, perhaps inferior to none. Gray, as three-quarter back, was also in good form. We doubt, though, whether he kicks quite as frequently as he might do; his place-kicks on Wednesday were not up to their usual good form, but great allowance must be made for the wind which was somewhat high.

Maclean's runs were as good as usual, and the passing of the three half-backs proved very annoying to the twenty-five.

It is the forward play of the Guy's men, however, which is usually so superior to their opponents, but this year they will very possibly have to meet the splendid forward play of the St. George's men, which will tax all their efforts. They now play together much better than they did at the commencement of the season, and with Pinching to lead, and such men as Rendall, Mutch, H. Duke and others to follow, they will not be easily defeated. Our hopes for Thursday next rest chiefly in our forwards, and if they play together as well as they did on Wednesday last we do not fear the result.

Last Thursday, on the Oval, the first and only match of the third set of ties was played between St. George's and University, when the former were victorious by a try and six touch-downs to nothing. There were a great many spectators and considerable interest was excited.

The forward play of the St. George's men was very fine, as was also the play of Collins and Jennings behind the the scrimmage. For University, Alford was as usual conspicuous, but they were manifestly over-matched throughout. On Thursday next the final match will be played between Guy's and St. George's, and we await the issue with much anxiety.

Last week St. George's played St. Bartholomew's, completing the second set of ties; the former were easily victorious, and thus the hospitals left in for the final ties were St. George's, Guy's, and University.

NOTES ON HISTOLOGY.

(From Dr. Pye-Smith's Demonstrations of Practical Physiology.)

(Continued from page 148.)

Mounting.—In mounting in glycerine, take care that none of it goes beyond the edge of the cover-glass, and that the gold size and asphalte is sufficiently thick. For this purpose work it up with what is dried. If too thick, dilute it with chloroform, and use this for washing your brush in afterwards. If you use Canada balsam or dammar, take care to extract all the water from the sections, by soaking them first in absolute alcohol. Sections from tissues hardened in chromic acid usually need clearing with turpentine or oil of cloves after this drying, before being put in Canada balsam.

Of the *staining agents* used, carmine, first used in 1858 by Gerlach, is the most generally applicable. It stains nuclei and axes of nerves fibres most deeply, protoplasm next, and inter-cellular matrix, fat, horn, &c., not at all.

Logwood, introduced by Boehmer, and magenta, by Dr. Roberts, of Manchester, behave much like carmine, but the latter has the disadvantage of fading.

Silver staining (Reckinghausen) is specially applicable to endothelium of serous membranes and lymphatic vessels.

Gold (Cohnheim) stains the protoplasm of cells, not the nucleus or intercellar matrix. It is most applicable to ganglion cells.

Perosmic acid (Max Schulze) defines cilia, and the delicate cells of nervous structures.

Palladium (F. E. Schulze) is applicable to muscular fibres and fresh cells.

Measurement. You can always estimate the relative size of the objects you examine by introducing one of known size into the field. A frog's blood-disk (whose long diameter is one-thousandth of an inch) is the most convenient for this purpose. And by drawing with both eyes open so as to bring the image of the objects on to the card, you can get them of their exact relative size. But as soon as possible have an eye-piece micrometer fixed in your deep eye-piece.

Accessory Apparatus. I have already spoken of the practical uselessness of the various contrivances for viewing objects by reflected light. Equally useless is the erector, for dissecting under low powers: a simple microscope or a mere hand-lens is much better. A polariscope is also of little use except in some more difficult branches of research. There is some convenience in an eye-piece indicator for pointing out any object in the field to another observer, and if you make a large cabinet of slides, you may find it worth while to adopt one of the means in use for finding a minute object under a large cover-glass. More important is an achromatic condenser, which, with eighth and higher powers is often indispensable, especially if you should be unluckily obliged to work by artificial light. Perhaps the most convenient addition you can make to your microscope is the double nose-piece, for holding two objectives at once, which was devised by Mr. Charles Brooke. Many find a "clip" and whirling-table convenient, though others find they can mount as neatly and efficiently with the unaided hands. For details as to the many methods of mounting and arranging specimens which are in use, I must refer you to the works of Dr. Carpenter, Dr. Beale, and the newly-translated hand-book of Professor Frey. After a little experience any one who works at the microscope finds out numerous plans of his own, and devises such improvements as suit his convenience. After all, remember that a man who draws but does not mount his specimens will know more of Histology than one who has an excellent cabinet, but has never learnt to observe and outline microscopic objects.

Lastly, let me urge you to use the microscope, not as a toy, but as a an instrument of anatomical research. English makers and English microscopists have too often wasted time and labour over mere mechanical and optical trifles. If any of you belong to the favoured class to whom money is no object, I would still advise you to have your microscope small and simple, with the best possible "fifth" and "eighth" objectives, but with only one low power and two eye-pieces, an unencumbered stage, and a monocular tube. Spare your eyes by working in daylight, and with both open. Spare no trouble. Work with your fingers more than with rackwork, and with your brains most than all.

Books Recommended. "Notes of a Course of Practical Histology for Medical Students," by Professor Rutherford ("Quarterly Journal of Microscopical Science," vol. xii. p. 1); "Dr. Payne's Paper on Students' Microscopes" (Ibid. p. 56); "Report on Modern Microscopes," by Dr. Michael Foster (Hardwicke) reprinted from the *British Medical Journal*, 1866-7; Dr. Carpenter, "The Microscope" new ed.; Dr. Beale, "How to work with the Microscope." Quain and Sharpey's "Anatomy (vol. 1 of last edition). "Frey: das Microscop," (this has been lately translated in America, and there is also a French edition).

Reports of Cases.

CASE OF ERYSIPELAS COMPLICATED WITH SCARLATINA.

(Reported by Mr. Kidd.)

E. H., æt. 31, admitted into No. 13, Inner Samaritan Ward, on Jan. 6th.

Is a carman by occupation, has been in the habit of drinking freely. Ten days before admission received a poisoned wound on the right hand, followed by red lines up the arm and swelling in the axilla. Three or four days before admission noticed redness and swelling about the right elbow.

On admission, patient is semi-delirious. Has erysipelas about right elbow and neighbouring parts, and general redness on both arms and chest; very little, if any, on legs; the redness is in large patches, some parts being more distinct than others.

Jan. 7.—Very violent last night, speaks incoherently, has great soreness of throat, which is ulcerated, voice husky.

Jan. 8.—Slept well last night, calmer this morning, throat worse, can hardly put out his tongue. No albumen in urine. Pulse 88, temperature 99·6.

Jan. 9.—Throat not quite so sore, redness of skin nearly gone, both arms the chest and scalp are desquamating in large flakes. No desquamation of legs.

Jan. 11.—Throat better, erysipelatous inflammation of right arm gone, the only remains being a circular piece of healthy-looking skin with sloughing margin, about the size of a shilling; this came away this morning. Pulse 99, temperature 80.

Jan. 20.—Very slight soreness of throat now; right foot

desquamating a little, all the cuticle has peeled off both hands; wound granulating.

N.B.—Patient says one of his children had scarlatina five weeks before he came into the hospital.

CASE OF IODISM,

We have been favoured with the following by an old Guy's man, now House Surgeon at the Carlisle Infirmary:—

J. S., æt. 36, admitted Sept. 24, with an epithelial growth on the arm.

The tumour was first painted with linimentum iodi, four days after admission.

On Thursday Nov. 5, it was noticed that the growth absorbed a larger quantity of liniment than usual; on the following morning his eyelids were swollen and stiff, and his legs and face œdematous, his nose discharged a large quantity of thin watery fluid, and he complained of supra-orbital pain, he had a feeling of tightness across the chest, and a feeling as if there were some foreign bodies in the bronchi, but he coughs up nothing. His eyes were inflamed and bloodshot, acne had broken out over his face, there was a distinct odour of iodine emanating from his body, and iodine was found in the saliva, there was albumen in the urine, but no iodine, also some in the lachrymal secretion,

Nov. 11.—℞ liquor potassæ mxij ter die.

Nov. 14.—Breathing very bad last night, was obliged to sit up the whole of the night. Urine ℥ 1 ℥ 18, almost solid with albumen, contains a number of granular casts.

Nov. 15.—Quantity of urine passed in the twenty-four hours is ℥ 1½.

Nov. 20.—Breathing much better, does not give him any trouble at night, very little discharge from the nose, urine still contains a large amount of albumen.

From this time the amount of iodine in the secretions rapidly decreased, the dyspnœa and coryza diminished, and the patient was soon convalescent, as far as the iodism was concerned.

Correspondence.

[We do not hold ourselves responsible for opinions expressed by our correspondents.

To the Editors.

Gentlemen,—The writer of your opening article in last week's *Gazette* is evidently inspired by a hearty dissatisfaction with the present attitude of the majority of medical men towards the great problems of diseased action, and I confess that to myself this indication of enthusiasm for something better is very refreshing to contemplate. But I think that he shows an impetuous desire for generalization, which, if carried into practice, would be fatal to the realisation of his ideal. As men, who have taken upon us to help and alleviate suffering humanity, we are bound to be acquainted with certain clinical entities for which we have a special classification and nomenclature, and we associate with such what means of cure or alleviation or assistance experience and common sense dictate.

It has been said that the different objects in the world are classified in the ideas of men just as seems most fitting to their relations to them in their several callings. Thus a whale is a fish or a cetacean, as the observer happens to be seeking for blubber or studying Zoology; to the gardener the natural orders are of far less consideration than whether his plants are flowering-plants or shrubs, annuals, or perennials; so, again, soils are one thing to the farmer and another to the geologist.

As *scientific* men, disease should assume quite a different aspect from what it does to us as *practical physicians and surgeons*.

Hughlings Jackson is setting a noble example to the profession by his "Empyrical and Scientific Investigations of Epilepsies." As a scientific man he repudiates the clinical entity of "true epilepsy," and endeavours, by studying the varied forms of epileptiform convulsions, those of "true epilepsy" included, what are the physiological bases of them all, and possibly he will, at the same time, find out for us something as to the nature of those mysterious processes which are the substrata of consciousness and motion. How can we possibly expect to bring into correlation the multitudinous phases of disease so long as we remain ignorant of those subtle processes by which we live and move and have our being? Is it not likely, nay is it not obvious, that the lines by which we shall travel towards this knowledge will rather be the careful scientific investigation of the phenomena induced by the *varied* deviations from the *single* normal purpose of our tissues and organs, than by turning our backs on them, shutting ourselves up in our laboratories, and following the more palpable changes in the living, if not tortured, bodies of lower animals, which, nevertheless—*vide* Dr. Carpenter's reply to Professor Huxley, on Human Automatanism—may prove an ignis fatuus?—Yours truly,

Enthusiast.

The Wards.

MEDICAL.

The following Cases were admitted between Feb 11 and Feb. 18:—

Philip—3—Chronic rheumatism. 8—Acute rheumatism. 12—Chronic bronchitis. 13—Acute rheumatism. 28—Bronchitis, 31—Periostitis of humerus.

Bright—4—Dyspepsia. 23—Quinsy. 24—Chorea.

Addison.—3—Gastric ulcer. 5—Amenorrhœa, 15—Scirrhus pylorus (?) 30—Chorea. 35—Dyspepsia.

Stephen—13—Tubular nephritis. 25—Acute rheumatism. 28—Bronchitis. 32—Pyrexia. 39—Hepatic abscess (?) 50—Emphysema.

John—12—Pyæmia (?) 15—Cerebral tumour.

Miriam—19—Tonsilitis. 22—Pneumonia. 24—Typhoid. 26—Syphilis. 29—Hysteria.

Mary—8—Gastric disturbance. 15—Hysteria. 24—Dyspepsia.

SURGICAL.

The following cases were admitted between Feb. 11 and Feb. 18:—

Accident—Concussion of right facial paralysis. Fractured ribs. Emphysem. Pott's fracture.

Naaman—4—Chronic periostitis. 5—Fractured fibula. 7—Fracture of humerus, and lacerated wound of hand. 8—Lacerated wound of dorsum of hand. 9—Synovitis. 11—Fractured tibia and fibula. 11—Punctured wound in femoral region. 14—Dislocation of patella (external) 17—Synovitis. 16—Compound fracture of tibia and fibula. 19—Supposed stone, adherent prepuce

Dorcas—2—Fistula. 7—Effusion into knee-joint. 9—Pistol bullet wound of lower jaw, concussion. 13—Burn. 14—Abscess of breast. 17—Fractured tibia and fibula. 18—Bursitis of patellæ.

Samaritan—Phymosis.

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Guy's

Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 21. SATURDAY, FEBRUARY 27, 1875 TWOPENCE

OF all things connected with this Hospital its mortality is of paramount interest, both to ourselves and to the public. To the public as a vague whole, in which the result of the baffled knife, or the vanquished drug ranks equally with that of a hopelessly fatal malady, towards making up that percentage by which they are pleased to judge of the value of the institution. To us, as the chief means of scientific research, as the greatest aid in our philanthropic aims. Guy's Hospital is fortunately independent of voluntary contributions, and therefore yields no servility to public opinion. The study of morbid anatomy is not hindered by the fear of a high death-rate. The dying pauper is not hurried to the workhouse lest he should add to it. Unhampered charity stands at our gates, with arms wide open to disease. No desire to parade a long list of cases "relieved" with a trivial mortality binds the hands of the good Samaritan, who, sternly disregardful of public censure, takes the dying phthisis by the hand, and soothes his last few days by the comforts of this hospital.

And so, perhaps, we see a large share of chronic cases at their termination. Chronic cases, which students like to speak disrespectfully of, and often pass heedlessly by as unworthy of their notice. Perhaps a run of incipient phthisis to make up the list of cases "relieved" is somewhat monotonous, and to a certain extent uninteresting; but when the individual "charity" can afford *post-mortems*, the morbid anatomy of phthisis and other chronic disorders forms the choicest pathological luxury. And, of the particular disease instanced above, the students here have, during the last few months, had unusual opportunities for pathological inquiry. The *post-mortem* table has revealed the complete uncomplicated tuberculous destruction of the lungs, side by side with every variety of complication. The specimens of phthisis proper have chiefly shown the usual cavitation at the apices, with a downward progressing tuberculo-pneumonic destruction, the cavities in one case being amongst the largest on record. In other cases tough iron-grey and yellow indurations monopolised the greater part of the organs; while a few were considered to represent purely pneumonic phthisis. The complications have been interesting and severe. The most noticeable being pneumonia, bronchitis, bronchiectasis, ulceration of the bronchial tubes, larynx, intestines, and into the vessels, aneurism of branches of the pulmonary artery, chalk stones, nodules in the testes or other organs, and markedly in three cases extensive emphysema. Croupous pneumonia was the immediate cause of death in a few cases, it led to a temperature of 104, and was usually associated with a rapid dissemination of tubercles over the lower lobes in connection with old phthisis above. Bronchiectasis in two cases constituted almost the whole disease. Both were young women from Clinical Ward, both had a history of pleurisy, both had the upper lobes shrunken, and consisting almost entirely of cavities formed by dilated bronchial tubes; while the lower lobes in one case were in a condition of œdematous pneumonia, in the other a mixture of this and breaking down lobular pneumonia. Ulceration of the larynx, and intestines with tubercles on the peri-

toneal surface has been almost constantly found in true phthisis; and, what is most interesting, in the pneumonic phthisis as well, while no such conditions were present in the two cases supposed to be phthisis, but which proved to be simply bronchiectasis, and pneumonia. Evidence such as this goes far to prove that all phthisis is tubercular, and, indeed, histological observation, if it does not positively assert the similarity of these various naked-eye conditions, yet shows a small-celled alveolar growth thickening the walls of the air-cells in these pneumonic cases in such a manner as to make it indistinguishable from admitted patches of tuberculous infiltration. May not the difference be in the distribution of the tuberculous growth? At one time it prefers the peri-vascular sheath, at another the bronchioles, or perhaps it springs up more universally in the walls of the air-cells, constituting pneumonic phthisis. In two out of the three cases of marked emphysema, the disease had not involved much more than the upper lobes, showing the grave] prognostic value of this complication. On the whole, more varied specimens of phthisical lungs could not be desired than have been witnessed in our *post-mortem* room this winter. It may be true that a greater number of cases of uncomplicated phthisis die in the hot summer months than during any other time in the year; but it is equally true that as many more would wait for the oppressive weather, if the cold winter months left the original disease uncomplicated. Perhaps we can do nothing for the disease; but we may save years of life, if we can ward off its complication.

Besides phthisis, however, other lung troubles ending fatally have been numerous. Bronchitis, emphysema, and pneumonia constituting the majority of the remainder. Two cases of acute lobar pneumonia died within three hours of admission, while one of acute lobular pneumonia in an adult died on the tenth day. As usual this latter affection has been more common amongst children. Perhaps the most interesting of these other lung cases were one or two of undoubted breaking-down disseminated lobular pneumonia, in no way associated with phthisis.

Of heart affections there has been no lack, mostly of the usual description; but very good examples of fibroid and fatty degeneration have also been observed.

Aneurism of the aorta has been a cause for tracheotomy in two cases, in neither of which was more than one pneumogastric nerve found to be involved.

and kindly allures the infected prostitute to the seclusion of other wards, until all fear of dissemination of syphilis is

Several cases of cirrhosis of the liver occurred together, in most of which ascites was absent.

The association of gout, lead poisoning, and contracted kidney has been demonstrated; with every other form of kidney affection.

Lardaceous disease has been found with syphilis, phthisis, and chronic suppuration, the latter chiefly in old hip disease in children, which has come first to excision, then to amputation, and lastly to the *post-mortem* table.

Cancer in great variety has added considerably to our mortality. Two cases were specially noticeable through the immense size attained by the growth in the liver, the organ weighing from ten to twelve pounds, and having scarcely any healthy structure left.

Of cerebral cases the last has proved the most interesting, it being a case of acute cerebritis, which is as rare as it is remarkable. Others, as is usual in general hospitals, were mostly dependent upon tumour.

In three cases of articular affection, hæmorrhage into the joints has been found. In two of these gout was present, in the third osteo-arthritis.

Of fevers, typhoid has been the only representative, but there has been plenty of pyæmia, and some cases of erysipelas, one of which was said to be complicated with scarlet fever.

Idiopathic anæmia, leucocythæmia, acute rheumatism, croup, gout, diabetes, acute tuberculosis, myelitis, tropical abscess, dermoid and other ovarian cysts, surgical injuries and operations, with many other cases have gone to make up the long list, that has contributed its share to science during the past few months at Guy's Hospital. We hope that Guy's students have reaped the advantages that have been offered to them.

A STUDENT'S NOTES OF

Lectures on Midwifery.

By J. Braxton Hicks, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

Lecture XVI.

Inversion of the Uterus.—Supposing the placenta firmly attached to the *fundus uteri*, and the funis very short, and that with a violent impulse the uterus had given its final pain; supposing immediately the fundal portion became flaccid, you will readily conceive that a certain amount of indrawing or cupping of the fundus might take place. And, then, when you consider the peristaltic wave of the uterine action, you can without much difficulty perceive the fundus protruding into the lower part of the uterus, would be treated as a foreign body and be driven down, as is the wont of the organ with all extraneous matter within it. Thus the partial inversion is completed, and the uterus turned inside out. Or if, anxious to cause the uterus to

contract in *post-partum* hæmorrhage, you so deeply impressed the fundus of the flaccid uterus down so far that it could be seized by the lower part and propelled downwards, you will also understand how complete inversion is accomplished; or if, as in the first instance, with a firmly attached placenta, you draw the fœtus out of a flaccid uterus, the funis being short, you might by your pulling wholly be the agent in the production of inversion of the uterus. Cases of this kind are not so very uncommon. I was asked to see a woman who, some six or seven days before, had been delivered by the forceps, the uterus being very inactive. There was no difficulty in delivering the fœtus, but before the placenta was separated, the uterus with the placenta still attached, appeared at the vulva. Such was the severity of the collapse that it was thought the patient could not bear manipulation sufficient for the restoration of the uterus. The medical attendant therefore peeled off the placenta, and gave stimulants freely. After a time she rallied, but as there was no flooding they left her for some days, and then asked me to see her. I found the uterus inverted, the cervix still flaccid. I placed her under chloroform, and passing the hand into the vagina, and grasping the organ, so as to express the fluids from its vessels, I gently pressed it upwards. In a few minutes it yielded, and towards the end of the process escaped rapidly from the grasp. I followed it in by the fingers, and found its restoration complete. I detained the fingers there for a few minutes, and gave secale. She was kept at rest rather longer than usual, and progressed well.

A similar case occurred to two gentlemen who were delivering by forceps. They peeled off the placenta, and grasping the inverted organ endeavoured to restore it, but they failed. After many attempts, they were thinking what next to do, when Nature herself assisted them, for on re-examination the organ was restituted. The fact was they had half restored it, but beyond that it would not go. No doubt the lower portion contracted firmly and thus pressed the fundus, which was within the os, upwards.

But a case occurred in our charity, in which nothing but natural forces were concerned, for the student not arriving till the whole was over, did not interfere nor examine at all. There was afterwards during the night a rather free loss of blood, but nothing alarming occurred till next noon, when on rising to pass water, she sat up in bed, and suddenly something came down; large hæmorrhage occurred, she became faint, and died before any one could arrive. I was there shortly after, and found the inverted uterus external. I tried to restore it, but failed; it was rigidly contracted. But sometimes it is not completely inverted, the fundus being near the level of the os. In the lecture on *post-partum* hæmorrhage I narrated such a case.

In our museum you will see a specimen of a partial inversion. You may have much hæmorrhage both in partial and complete, if the placenta be detached wholly or in part, but, of course, if wholly attached you will have none. The amount of shock varies much, in some there is none. I remember two cases, which wholly escaped the notice of the attendant. In one the nurse, about the tenth day, told the doctor there was "something down." Little thinking its nature, he said it would come all right; whereas I was asked to see it some months after, as a case of polypus, which it simulated much. This case should be a caution to you and to all, always to see at once into the exact nature of anything complained of. If it be nothing, so much the better; but if anything important, the sooner treated the better. At the time mentioned nothing should "come down." If it be a swelling of the parts, this requires looking to; if it be prolapsus uteri, it requires treatment of some kind before the patient is about again, which should not be delayed; if it be an inflamed pile, it requires attention. The inversion at that time might have been restored, but at the time I saw it, although I made many and protracted efforts I failed to do so, and this not without great risk from the severe collapse attending the compression of the uterus. She, however, so far recovered as not to be seriously affected with metrorrhagia, as is commonly to be found in cases of chronic inversion. The other case was without any special indication; she had no hæmorrhage, no collapse, no pain, and she came to me for a "falling of the womb." Some months after I wrote to the attendant, to know if he was aware of it, but he said he had heard of nothing unusual whilst he was in attendance. Hers I was able to re-instate by slow pressure after three days, though at first I attempted immediate restoration, during which attempt the manipulation plus chloroform produced such collapse that she ceased to respire for two or three minutes, and was only by active faradisation recovered.

With regard to the physical diagnosis of complete inversion, the only thing with which it may be confounded is a polypus uteri. In the recent case, the placenta being attached, it is like a case where a large polypus exists, on which the placenta is implanted. To clear this point, you must peel off the placenta, because in any case that is first thing to be done. Then pass the hand within the vagina, and examine the root of the projecting mass. If it be a polypus you will find you can pass up into the cavity beyond some distance. In the case of an inversion, you may pass a little way, say an inch, in the complete form, and two or three in the incomplete, when progress is arrested in every aspect of the root. But, at the same time, place the hand over the position of the uterus. If it be a polypus, you will find the large mass of the uterus in its proper place, while in the case of inversion the uterus will be wanting, and in its place a cup-shaped depression, with both hands acting together, as they always should do in such examinations, you will readily perceive the distortion of the parts. Just after delivery the abdominal walls are so lax that the examination can be carried out very readily. In the more chronic condition, when the size of the organ has by involution been reduced, the resemblance to a polypus is increased. The use of the sound makes the matter very clear. Indeed, in all cases of polypus we should pass the sound, searching all round the root for the passage to the uterine cavity, the point exploring the circumference line by line. But where the polypus springs from the very edge of the os, then the finger ordinarily detects the cervical opening. However, when the sound is passed up, the hand should be placed over the pubes to feel the uterus and the sound within it. The length of the part within the uterus should correspond with the natural length of the organ.

The treatment of the cases as they occur just after labour has been already fore-shadowed, but to place it more clearly follow these rules—

1. Give a stimulant, if any tendency to collapse.
2. Peel off the placenta.
3. Grasp the uterus by both hands if it be outside; if inside, pass one hand within the vagina, and then grasp the uterus. Compress it gently and slowly till it becomes smaller, when it seems smaller, gently push it upward

through the yielding cervix, retaining the grasp till it has passed within the cervix, then withdrawing finger by finger, push it completely up by the tips; grasp now the organ externally, and, if it be in normal shape, give a dose of secale to fix it permanently. If there be much difficulty to restore it, then place the patient under chloroform, and again make the attempt.

Keep the patient on the couch longer than after a usual delivery.

Physical Society.

At the meeting of the Physical Society, held on Saturday, February 20, a paper was read by Mr. Symonds, entitled "Some notes on the symptoms of Rheumatic Fever," of which the following is an abstract:—

Eleven cases were admitted into Philip and Bright in September, October, and November. Of these six had complications of some kind. Three had double pleurisy, three had peri-carditis and pleurisy. Brief notes of eight of these cases were then given, and the following conclusions drawn—

1. A patient with many joints affected; free or no sweating; moderate temperature; quiet manner; no pain except when moved, is less liable to complications than one with only one or a few joints affected, or than a patient having many joints affected but who is restless, in pain, and anxious.

2. Absence of joint affections (after previous affections); retained high temperature; absence of sweating (after previous sweating), a peculiar restlessness—point to some complications.

3. Large effusions may exist in both chests without much danger; the effusion into one chest is accompanied with pain, while in the other there is no pain.

4. Examining a chest and finding of a double pleurisy, with little uneasiness, normal temperature, no joint trouble—one would say, Acute Rheumatism had existed.

5. Considering the heart as a joint, it is as open to attack, at any time of the disease, as any other joint. The cases cited showed that the moment the heart was affected the joints improved. Heart not attacked in same manner as the joints, differing in the following particulars:—

a.—Disease remains a short time in the joints, a long time in the heart.

b.—The result of attack of the heart is, formation of lymph, adhesions, and partial or total obliteration of serous cavity, whilst in joints none of these occur.

c.—The fluid in the case of the heart is in the serous cavity; if the joints are affected the same as the heart, the fluid in the former ought to be in their cavities, and, as there is heat and redness, lymph would be expected; this is not found, which may be explained by there not being time for the organisation of the serum; and joints being able to rest whilst the heart must move. Against the idea that the fluid is in the joints is the fact that the swelling comes and goes so quickly, whereas in a surgical case, fluid is not quickly absorbed by serous membranes. Hence fluid is not in the joints, but probably around them.

The disease was shown to exist in the ligaments. The swelling was explained by the inflammatory action extending into the surrounding tissues, the sudden pain by the structures attacked being tense. The rapid disappearance of swelling by the cutaneous and subcutaneous tissues absorbing fluids more readily than the serous. Over the pulmonary artery the second sound was found accentuated in four cases of peri-carditis, but not in the uncomplicated cases listened to. It was thus explained—in health the anterior margin of the left lung rests between the pulmonary artery and parieties, when the heart contracts (increasing in antero-posterior diameter) it drives forward the pulmonary artery which pushes slightly aside the lung. Should any cause arise to remove this piece of lung, the whole force will be used in driving forwards the pulmonary artery, which will thus reach the parieties. When pericarditis ensues, the fluid extending the cavity pushes aside the lung, allowing the pulmonary artery to come forwards to the parieties. A distinct impulse can be felt in the second space. The sound is diminished by a long inspiration as convalescence advances. This sound was considered as an indication of commencing pericarditis. The laboured or "tailed" first sound of the heart often heard may develope into a bruit, as in a case cited. From the similarity between acute and gonorrhœal rheumatism they were both thought to be produced in the same way, viz., by the absorption of material, the former from the alimentary, the latter from the urethral canal. Pathology seemed to indicate a supporting treatment.

Mr. Shadwell, in opening the discussion, said the paper was a most interesting one, rheumatism being a disease which affected both rich and poor alike. In one case, he had seen, of low temperature and dry skin, there was a good recovery without complications; but he did not know whether they were to take those conditions as always leading to the same result. In most cases of hyper-pyrexia all the sweating ceased, therefore it did not seem that a dry skin was a favourable condition. Babinger had shown that heart complications were in proportion to the number of joints affected. Dr. Wilks had mentioned a case in which the first indication of rheumatism was pericarditis, therefore it was not correct to say that rheumatism always commenced with joint affection. With regard to gonorrhœal rheumatism, so many men suffered from gonorrhœa that it was difficult to say whether it was rheumatism with gonorrhœa or gonorrhœal rheumatism. If the joint troubles were due to absorption of the discharge or its products, ought it not to be regarded rather as a case of pyæmia than of rheumatism? Acute rheumatism was probably of nervous origin. In favour of this he had noticed—especially in females—that it often commenced with facial neuralgia. Pleurisy, to a slight degree, was pretty frequent, but Mr. Symonds' cases were exceptional: they required no treatment; the fluid would get absorbed.

Mr. Green, in remarking on the frequency of heart disease as a result of rheumatism, said that disease of the aortic valve might be due, in adults, to disease of the vessels, or aneurism; but in children these causes did not exist, therefore they must fall back upon rheumatic fever. A child might come with severe heart disease, and the mother deny that he had ever had rheumatism, but on close questioning, a history of some slight swelling about the joints might be obtained. Some one or two of such cases he had seen. Rheumatic fever in children was often overlooked, it being at times very slight, and not compelling them to keep in bed. He thought the joints most used were most commonly affected, rather than, as Mr. Symonds had said, those most exposed. Heart disease was much more common as a sequel of rheumatic fever than in adults. This might be because the heart beat quicker in them. There was a patient in the wards where a click could be heard over the second space, probably due to the pulmonary orifice. The more severe the rheumatism the more severe the sweating.

Mr. Coley wished to call their attention to the question of temperature. Dr. Habershon had made the remark that in any case where the temperature kept up, and the pain went away, there was a sign of immediate danger. He did not seem to give any very definite explanation of it, but mentioned it as a clinical fact. It was borne out by all the experience he (Mr. Coley) had had of the subject. He did not think it an easy thing to explain, but it might be due to the sensorium becoming blunted as the mischief increased. If the case began well, and the temperature kept pretty low, it did not seem to matter much whether there was sweating or not; but it was a very grave indication if sweating should be very profuse to begin with and then suddenly cease. It was an almost certain sign of hyper-pyrexia. As a rule, the heart was not attacked first, but it might happen that the heart would be affected without anything else, to any sensible degree. There might be thoracic complications—heart disease included—without any pain being produced. If this should happen without any joint affection, it was not likely that anybody would know anything about the disease. This might explain some of the cases of heart disease that came before them without any history of rheumatism or chorea.

Dr. Fagge had mentioned once a theory that rheumatism depended upon lactic acid in the blood, and he had pointed out the fact that if patients, when nearly convalescent, be put upon meat diet, they would most certainly have a relapse. He (Mr. Coley) had seen that, on two or three occasions, but whether it depended upon lactic acid being formed as the result of this injudicious use of nitrogenous food he did not know.

Mr. Fry did not think that Mr. Symonds was right in saying that the heart was never affected without, nor before, the joints, in acute rheumatism. Accentuation of the second sound, Mr. Symonds looked upon as an indication of pericarditis. In uncomplicated cases, *i.e.*, where the heart had not previously been affected, it might be of use, but not in any case where heart disease already existed, because that very sign was already a means of diagnosis between systolic apex and systolic basic bruit.

Mr. Duke had lately noticed a symptom which had not been mentioned by Mr. Symonds, namely, deafness. He could give no explanation of it. Slight attacks of rheumatism were often followed by more serious complications in children than in adults. He saw no reason why acute rheumatism should not be caused by the presence of lactic acid.

Mr. Hetley had often heard the accentuated second sound over the base, but did not quite agree with the explanation given. It was said to be a forerunner of pericarditis, but to become audible owing to distension of the pericardium with fluid, which was a sequel of pericarditis. He thought the dull first sound at the base very distinctive in rheumatic fever.

Mr. Jones said there had been two or three signs brought forward as guides for the onset of pericarditis—Mr. Symonds' accentuated second sound, and Mr. Clarke's variation in the pulse-respiration ratio, but neither of them told them when pericarditis was coming on, but simply that it had come on. To find out some symptoms that should indicate that inflammation was only coming on, would be rather difficult; in fact, he did not see how such a symptom could exist. The only possible condition, he could see, that would be at all in that way would be the disappearance of the inflammation from the joints suddenly. But it was a still greater question that would not be due to the fact that pericarditis already existed rather than that it was going to be set up.

Mr. McCarthy said they had heard the causation of rheumatism spoken of in connection with the serous, fibrous, and nervous structures. He did not think serous membranes were the first cause. It was the rarest thing to get the peritoneum affected, or the membranes connected with the brain and spinal cord. The fibrous tissues involved are only those in connection with the joints or heart, where there was also movement. He supposed that the relations between the joints and heart was not more than that there was movement and tissues alike in both. As to the nervous, that certainly would appear to have some important part in it. Rheumatic fever was often brought on by a "chill." A shock to the nervous system in some way influenced the blood. Traced up to its first cause the only thing noticed was that there was some alteration in the blood.

After the usual vote of thanks to the reader of the paper, the meeting adjourned.

Our esteemed consulting surgeon, Mr. Cock, has had the honour conferred upon him of being appointed a Justice of the Peace for the county of Surrey.

A DISSECTION of the KIDNEY from BEHIND.

By W. H. A. Jacobson and R. J. Pye-Smith.

In the supine position of the body and during expiration the kidneys rest about equally upon the diaphragm and the quadratus lumborum muscles, to the outer side of the bodies of the last dorsal and first two lumbar vertebræ. Owing to the greater length of the left kidney its lower border usually reaches somewhat lower than that of the right. The common statement that the left kidney is placed higher than the right is probably incorrect. Dr. Sibson ("Medical Anatomy") gives eight instances of the right being the higher out of thirteen observations, and in the four cases in which we particularly noted the point the lower border of the left was always below that of the right, and in three cases the upper border was so also, the spleen rather than the liver appearing to push the corresponding kidney downwards and somewhat inwards.

It is intended here to indicate briefly the dissection of the smallest rectangular space by which the kidney of either side may be entirely exposed from behind. Variations in the size and position of the organs in different subjects allow only of an average being given in the extent of the incisions.

The chest is supposed to be (as it naturally is after death) in a state of expiration. The subject is to be placed in the prone position, and the following incisions are to be made in the lumbar region:—

1. From a point one inch from the middle line of the body opposite the lower edge of the tip of the spinous process of the eleventh dorsal vertebra, to a corresponding point opposite the lower edge of the tip of the spinous process of the second lumbar vertebra. This incision will be parallel with the spine, and from four to four and a half inches in length.

2. From the commencement of the first incision and at right angles to it outwards to the upper part of the tenth intercostal space. This incision should be two inches and three-quarters in length.

3. From the termination of the first incision parallel and of equal length with the second incision.

4. From the termination of the second incision to the termination of the third incision.

There will thus be divided off a rectangular piece of skin measuring about four inches and a quarter on the sides that are parallel with the spine, and two inches and three-quarters on the sides that are at right angles to the spine.

The upper border of the higher kidney will lie beneath the inner half of the upper line, that is, on a level with the lower edge of the spinous process of the eleventh dorsal vertabra; that of the other will be half an inch or less lower.

The lower border of the left kidney will lie beneath the middle of the lower line, that is, on a level with the lower edge of the spinous process of the second lumbar vertebra, and about an inch above the top of the crest of the ilium; that of the other will be half an inch or so higher.

The inner border of each kidney will lie beneath the upper half of the inner line, that is, an inch from the middle line of the body; and the outer border will lie beneath the middle of the outer line, that is, three inches and three-quarters from the middle line of the body.

Portions of the following structures lying between the skin and the kidney are then to be removed in order by dividing them successively along the edges of the wound:—

Bones.

1. Eleventh rib (about two inches of its shaft, including the angle).

2. Twelfth rib (all but its head), and, unless the rib be longer than usual, its costal cartilage.

3 and 4. Transverse processes of the first and second lumbar vertebræ.

Fasciæ, &c.

1. Superficial fascia including a mass of fat to the outer side of the erector spinæ.

2. Posterior (or superficial) layer of fascia lumborum (or vertebral aponeurosis) attached to the tips of the spinous processes.

3. Middle layer of fascia lumborum attached to the tips of the transverse processes.

4. Anterior or deep layer of fascia lumborum attached to the anterior surface of the roots of the transverse processes, and including the ligamentum arcuatum internum.

5. Fascia iliaca.

6. Ligamentum arcuatum internum.

7. Perinephritic fat (or tunica adiposa).

Muscles.

1. Latissimus dorsi.

2. Serratus posticus inferior.

3. Erector spinæ (viz., sacro-lumbalis or ilio-costalis, the outer half of longissimus dorsi, and the lowest two slips of origin of the accessorius and sacro-lumbalem).

4. Levatores costarum, and levatores longiores costarum of twelfth and perhaps eleventh ribs.

5. Intercostales externi of tenth (a small part) and eleventh spaces.

6. Obliquus externus abdominis (its origin from the twelfth rib).

7. Intercostales interni of tenth (a small part) and eleventh spaces.

8. Obliquus internus abdominis, its free edge, and part of its origin from the fascia lumborum and of its insertion into the twelfth costal cartilage.

9. Transversalis abdominis (its origin from the twelfth costal cartilage and perhaps a few fibres from the fascia lumborum).

10. Intertransversales laterales.

11. Quadratus lumborum.

12. Psoas magnus, and when present psoas parvus (their outer edges).

13. Diaphragm (part of the crus and its origin from the ligamenta arcuata, eleventh and twelfth costal cartilages, and intervening fascia.

Nerves.

1 to 3. External branches of the posterior divisions of of the eleventh and twelfth dorsal and of the first lumbar.

4. Eleventh intercostal (and perhaps a small piece of the tenth).

5. Anterior primary division of the twelfth dorsal.

6. Ilio-hypogastric.

7. Ilio-inguinal.

Arteries and Veins.

1. Intercostal of eleventh space (and perhaps a small piece of that of the tenth).

2 and 3. Dorsal and abdominal branches of the first and second lumbar.

Lymphatic Vessels.

1. Superficial (in the superficial fascia).

2. Deep (with the blood-vessels).

Pleura.

1. Parietal layer lining the eleventh and twelfth ribs, and the tenth and eleventh intercostal spaces.

2. Parietal layer covering the diaphragm.

(The two visceral layers with the wedge-shaped piece of lung, which in inspiration would fill this interval, will usually in expiration be just above the upper incision).

ON THE ACTION OF DIGITALIS.

(Notes from a Clinical Lecture by Dr. Wilks.)

You have often heard me speak of the value of digitalis, and probably most of you now know its use. A few years ago its action was not understood, and students were in great difficulty in determining the cases in which it might be properly administered. But we now know perhaps more about digitalis than any other remedy in the Pharmacopœia, and when using it we are adopting, as far as possible, a scientific mode of treatment. In fact we might call it a model remedy. We see a patient gradually going down hill, and we come in and give our dose of digitalis. It acts in a definite and immediate manner, all the symptoms lessen, and we frequently save our patient's life.

Digitalis has long been known to cause death, by bringing about a cessation of the heart's action, and, therefore it was said to be a depressant. Seeing that it was occasionally useful in cardiac disease, it was thought that it would prove in cases of inordinate action of the heart useful, by acting as a depressant. But we have since learnt that this idea is wrong, the real effect of the drug having been proved by experiments on animals. You open, for instance, the body of a rabbit, you insert some digitalis into any part where it can get easily absorbed, and presently you will see the heart begin to contract more tightly and more slowly, and become paler in colour. It will go on contracting more tightly and more slowly until it actually seems to become smaller, and at last it seems to you that there can be hardly any cavity left. Finally it will cease beating in *systole*. By the same experiment, it may be shown that, independent of its action on the heart, the drug affects the blood vessels in a similar way; they contract more tightly too, there being greater pressure on the vessels. Then there is a more striking experiment than this. Aconite will stop the action of the heart, but in exactly the opposite manner to digitalis. If you administer aconite, you will find the heart get more flabby; the blood vessels dilate instead of contract, and the heart also dilate and act more slowly until it will flap open in *diastole*, and cease to beat. It has lost all power. But the remarkable fact of the experiment is this: if, after the heart has come to a standstill from poisoning by aconite, you introduce some digitalis, you will find it begin to work again, and contract more and more firmly until it ceases to beat in systole. The heart of the rabbit, when poisoned by aconite, is similar to the condition we find after in the human subject as the result of disease. And when you give such a patient digitalis, the heart, as in the experiment, begins to contract more regularly and more powerfully, and not only when given to animals, does it reduce the frequency of the heart, and increase the arterial pressure, but the small arteries are observed to contract under its influence. It gives then "tone" to the heart; it does, in fact, what Nature does by hypertrophy. Some enthusiasts believe that if you well followed up the remedy, you would produce hypertrophy. It is in those cases then of dilated heart, where the systole is incomplete, that you order digitalis. Call it a "tonic," and then you will be all right, and have no fear of using it. There is an old prejudice that it accumlates in the

system, and may produce its fatal effects suddenly. I have seen patients die suddenly while taking digitalis, but only after they have had it a few days, therefore I do not lay the blame to the remedy. And, on the other hand, I have given it for months together, without its having caused any bad symptoms. I do not say I should wish to give it so long, because directly I found the effect produced I should stop it. But I do not think you need be so frightened about it as some of the older members of the profession are. If it acts in this way on the left ventricle, I do not know why it should not affect also the right. In many cases of bronchitis digitalis might be a useful remedy. I can imagine if the right ventricle were weak, we should do good by digitalis. Now and then it fails, in a class of cases in which I should have thought it would have proved useful. I can only explain this by supposing that the muscle is in such a state that it cannot be acted upon by the remedy. Then there is another important point connected with this drug, and that is it relates to alcohol. Those who would not have used digitalis in such cases as I have described, would probably have given alcohol. You see, for example, your patient with no pulse, sitting up in bed and breathless, and the first impulse is to give him some brandy. Now, the question is whether it would do any good; my impression is it would make him worse. I have had considerable experience in such cases, and have found that it has only made the heart beat more irregularly and quickly. I am inclined to think the two remedies act in a very opposite manner on the nervous system. This indiscriminate use of alcohol shows how little we know about it. If it is good in one case it may not be good in another. When alcohol is beneficial and when injurious I cannot exactly tell you. But I believe there is a morbid condition of the heart which it tends to aggravate. Take an ordinary case of nervous palpitation in a dyspeptic: you give digitalis and you do no good, but you find alcohol at once steadies the heart. The pneumogastric supplies the stomach and the heart, you put some brandy into the stomach and it quiets the other organs. My impression is, that in the case where digitalis is good, alcohol is bad and *vice versa*. I am not sure that alcohol acts in the same way as aconite, but I am not at all certain that it does not.

Sports.

FOOTBALL.

The heavy fall of snow on Wednesday last prevented the final ties from being played on Thursday. The match was consequently postponed till Thursday next, March 4.

The following is the team chosen to represent our hospital:—Backs—Breach and Pearson; Three-quarter back—Gray; Half-backs—McClean and Finch; Forwards—Pinching (Captain), Robson, Hetley, H. Duke, Wallis, Gilbert, Rendall, Mutch, Welchman, and Keer.

The following gentlemen were successful candidates at the recent examination for Her Majesty's Army, Navy, and Indian Medical Services;—Messrs. Beatson, W. A. Simmonds, and Williams.

Guy's Hospital Report.—Gentlemen desirous of becoming subscribers to the forthcoming volume of the above are desired to give in their names at once to Mr. Howse or Dr. F. Taylor, so that their names may appear in the list of subscribers.

APPOINTMENTS.

Obstetric Residents—
Messrs D. B. Lees, H. N. Smith, J. C. Ferrier.

Dressers—
Messrs C. Symonds, R. C. Carrington, Morgan, Shadwell, Coley, Bartlett.

Clinical Assistants—
Messrs J. B. Richardson, W. Brown, A. Finch, Welchman.

Assistant Physician's Clerks—
Messrs Oram, Grimwood, W. P. Reynolds, Justin McCarthy, W. M. Evans, W. P. Turner, Todd, Brett.

Dressers in Eye Wards—
Messrs Gibb, H. Duke, Romano.

Medical Ward Clerks—
Messrs Breach, Piggott, Fell, Dennis, Kidd, C.W. Lacy, Champneys, Mallam, Porter, Tarrant, Phelps, Gathergood, Stewart, Bevan, Chadwick, Waterhouse.

Surgical Ward Clerks—
Messrs Womersley, Deare, Osborne, Parke, Messum, Reynolds, Roper, Stewart Wood, Stanger, Magrath, G. H. W. Jones, R. E. Morse.

Assistant Surgeons' Dressers:—
Messrs. H. W. Roberts, H. H. Williams, J. Knight, A. Green, C. Creed, Don Bavand, Pedley, Cusack, Dutton, Ingram, Wilkinson, Richards, Instone, Turner, Hyne, Simon, Wallis.

Dressers in the Surgery:—
Messrs. T. Slatter, H. Stevens, P. F. Gilbert, W. P. Turner, A. C. Parker, C. Perry, E. C. Green, T. G. Jones, E. R. Mansell.

Obstetric Out-Patient Clerks:—
Messrs. A. Jones, B. Jones, Edgar Duke, J. Davis, T. R. Judson, J. Mackern.

Post-mortem Clerks:—
Messrs. B. Jones, T. A. Richardson, P. B. Williams.

Dental Surgeons' Dresser—
E. B. Williams.

Assistant Surgeon's Clerks—
Messrs. Pilkinton, Abbot, Wells.

Externs for March—
Messrs Finch, Collins, Carrington, Symonds, Bull.

The Wards.

MEDICAL.

The following Cases were admitted between Feb. 18 and Feb. 25:—

Addison.—9—Rheumatic fever. 32—Syphilis. 37—Dyspepsia.
Philip—1—Lead poisoning. 4—Phthisis.
John—5—Dyptheria. 8—Aortic disease.
Bright—1—Rheumatic fever. 11—Jaundice. 14—Peritonitis (?)
Miriam—27—Acute Bright's disease. 32—Rheumatism.
Stephen—5—Gout. 8—Acute rheumatism. 11—Phthisis. 18—Pleurodynia. 29—Morbus cordis. 37—Pleurisy. 40—Paraplegia. 42—Hodgkin's disease. 45—Morbus cordis. 47—Phthisis. 48—Chronic cerebral disease.
Mary—8—Chlorosis. 10—Peri-nephritic abscess. 17—Bronchitis. 15—Febricula. 16—Rheumatism. 18—Phthisis 23—Paralysis of left arm.

SURGICAL.

Mr. Lancaster Dresser for the week

Lazarus—4—Injury to ankle. 5—Concussion of hip. 7—Ulcer of leg. 2—Practured ribs. 10—Stricture of urinery fistulæ. 14—Epithelioma of hip. 19—Laceration of hand. 22—Sarcoma on thigh.
Martha—4—Suppurating bursa patellæ. 5—Abscess of thigh. 6—Laceration of forearm. 7—Mammary abscess. 16—Submammary abscess. 17—Talipes axillary abscess. 22—Fractured patella. Cot—Fractured femur.
Accident—Fractured fibula. Fractured tibia and fibula. Injury to head. 29—Fractured femur. 30—Fractured tibia and fibula.

We are compelled, through pressure of matter, to leave over the Notes on Histology—How to Make a Section of the Retina—The Dissecting-room, &c.

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BY SAMUEL WILKS, M.D., F.R.S.,

Physician to, and Lecturer on Medicine at, Guy's Hospital; and

WALTER MOXON, M.D., F.R.C.P.,

Physician to, and late Lecturer on Pathology at, Guy's Hospital.

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RAILWAY APPROACH,

LONDON BRIDGE STATION.

Printed for the Presidents of the Physical Society by ORLANDO G. BRENCHLEY, of Tennis Court, King Street, Borough, S.E.

Guy's

Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 22. SATURDAY, MARCH 6, 1875 TWOPENCE

LAST Wednesday brought to its close another brilliant season for our Football Club by a contest with St. George's that will long be remembered by all who witnessed it. The fierce struggle, the running, the kicking, the intense excitement and cheering of the spectators—form a picture that we shall look back upon in years to come with a worthy pride in the deeds of the old school; a picture that we shall recall when we are old, old in years, but which will make our pulse beat again with the freshness of youth, while the players in the Guy's team, like the old victors at Agincourt, will raise their heads with pride at every anniversary of March 3rd, 1875. The facts of the play are described on another page by our Football Correspondent, but it remains for us to heartily congratulate the Guy's team upon their becoming the first holders of the Inter-Hospital Football Challenge Cup, an honour which, while greatly to their credit, we are bound to say, in justice to St. George's, they by no means easily obtained. Popular favour ran high with St. George's, perhaps because they had already beaten the third and fourth hospital teams, while Guy's had only been pitted against two of the smaller hospitals, and had never, during the whole season, played full team. However, all turned up on Wednesday, and acquitted themselves like the wrestlers of ancient renown. None that witnessed the match could fail to be struck with the pluck and determination shown by the players; every man did his utmost, and so equally balanced was the immense strength on either side, that, on several occasions the forwards remained perfectly still for one or two minutes in a dense mass, when every muscle was strained to its utmost, as might be seen by the halo of aqueous vapour, and the fine facial contortions exhibited upon two or three heads, which the superior stature of their owners raised above the rest.

Many entertain the opinion that such athletic exercises as these are not consistent with student life: they would think that Wednesday's teams were composed of lazy, careless men. Such observers, if indeed they may be called observers at all, are narrow-minded in the extreme. Nothing is more requisite for the examination table than the indispensable pluck and determination of the Football field; while no better accessory can be added to the latter than a good head; in fact, the two play into each other's hands, and the victors at Burlington Gardens, on Wednesday evening, drank their loving-cup from their Inter-Hospital Football prize. So impressed are we with the value of these open-air contests, that, while we maintain the first importance of study, we urge all Guy's men to join some athletic club, not only as a relaxation to the weary hours of reading, or as a means of healthy exercise, but as the best way to obtain an independent spirit, and an unconquerable determination to succeed, which will help them far beyond the examination-table, through the sterner difficulties of life, under which many sink only through a lack of pluck.

We remind our athletes that Guy's Hospital looks proudly forward to another victory in the spring, and we offer our warmest hopes for their success to the competitors

of the Challenge Shield, while we thank and congratulate them for the Challenge Cup.

A STUDENT'S NOTES OF

Lectures on Midwifery.

By J. Braxton Hicks, M.D., F.R.S.

Obstetrich Pysician to, and Lecturer on Midwifery at, the Hospital.

Lecture XVII.

Rupture of the Uterus.—Like as a voluntary muscle may rupture itself by its own action under the stimulus of the will, so may the uterus tear itself under the stimulus of reflex irritation. On a healthy organ the tensile strain it can bear is very great before it gives way, and consequently, it is not till the pains have been put forth to the utmost that it yields. But when, from the presence of some fibroma in its walls, or from obliquity, distortion of some prominent part of its contents or other cause, the action is not equally distributed, then undue tensive force is exerted on some part, and it gives way. In an organ that has been weakened by disease, as inflammation, degeneration, &c., the extreme limit of resistance is quickly reached, and in some cases, even before labour is fairly established, a lesion takes place. A case occurred in our Charity, where before labour had fairly begun, the pains suddenly went off. At first there were no marked signs, but soon collapse came on, and the patient died before the gentlemen were fully alive to the true state of the case and its danger. Formerly, when the use of instrumental help was postponed unduly, the most frequent condition in which rupture occurred, was in obstructed labour with violent pains. In these the symptoms were strongly marked, abrupt, and easily recognised; but now these cases being less frequent, the more common are those where the weak uterus gives way upon the occurrence of feeble pains, the symptoms less marked, and apt to deceive; or rupture may occur from other causes. When the fœtal head is pushed by the uterus downwards against the rigid os, it sometimes happens that after the head has in part passed through it, the margin gives way, and thus the passage is opened; the head rather suddenly comes down into the cavity of the pelvis, a little blood generally escaping. If this rent of the cervix, which is generally laterally placed, is confined to the vaginal portion, no bad defects are felt, but it sometimes extends. I had a patient under my care in Mary Ward, admitted with cellulitis on one side of the uterus, on examinining internally I detected this kind of rupture, but it had extended up into the roof of the vagina into the broad ligament, and from this part the swelling could be traced. Doubtless the effusion was very salutary and protective to the parts beyond. How far it had gone into the uterus I could not tell, but in some cases it extends far up into the body, thus opening up the peritoneal cavity. I once had another form of rupture, which did not extend to the margin, but came to within an inch of it. It was in a primipara, and labour had proceeded nearly to the completion of the dilatation stage. But the uterus became irritable, and the patient showing signs that labour should be terminated, I was called in. I found the os sufficiently dilated to employ the forceps, and was about to apply them, when on carefully examining the state of the parts, as we always should do before proceeding to operate in any way, I found a rent on the left side of the uterus, extending three inches. As far as I could reach by the side of the head; however, it extended much further, for the edges there were an inch apart at this point. It did not go into the peritoneum, I should think, because we had no sign of such an accident, though that point cannot be relied on absolutely. The rupture was in the line of the broad ligament. As the equator of the head had passed the major part of the rent, I thought gentle traction of forceps would not increase it. I therefore placed them on, and with extreme care, brought the head through the os without further damage, thus saving the life of the child. The mother recovered without a bad symptom, of course she was kept at rest longer and more rigidly than usual. This, however is a rather unusual case, but there is another mode of rupture, which is brought about in the following way:—The uterus always, by its natural efforts, the head having passed through the os, pushes the head against the posterior wall low down, and at a later stage against posterior wall of the vagina. Thus this part is unduly stretched, and not being the most muscular part of the uterus, it may be, and sometimes is, torn through. This rent is generally transverse along the posterior half, or even more than that, indeed, it is highly probable that some cases of total separation of the uterus have occurred from an extension of this rent right round; and then, as the only structure which oppose the powerful recoils of the uterus against an obstacle are the broad and round ligaments, if these are feeble, it is not difficult to conceive how they may be rent asunder. For the only tissues that bear the recoil strain in natural labour are the cervix or the vagina, and the ligaments broad and round; but if you observe the uterus at full term, you will find the broad ligaments form really no support worth the name; the round only seem to hold the uterus from flying back when in full action, and these, when the attachments of the uterus below have been severed, may, without much stretch on the imagination, be supposed to give way. Of course the auxiliary forces support the uterus and take off a great part of the strain on them. But when they cannot act, the tension on the parts mentioned is great. However this may be, the posterior part of the uterus, when the head is within the os, does give way; and so does the posterior wall of the vagina, when the head has escaped from the os. But this lesion is more likely to occur when the head has been resting against these parts for a long time, and a certain degree of softening has taken place from pressure.

Another way that rupture may occur is from your own actions in turning. The rapid revolution of the fœtus in an active uterus, the outstanding of some member, the projection of your knuckles against the inner wall during a pain, may place undue tension on one part, and it yields. I saw a case of this kind in a fat, feeble-tissued Jewess, in whom it was necessary to turn the child. However, during the operation, while the child was being revolved the medical man was conscious of the rupture. The head was subsequently torn off from body, and I was asked to see her. I found a vertical rent through the lower half of the uterus and upper half of vagina in front, the head rolling about free in the upper part of uterus. She was dying at the time, and before I could

get to work she sank. This uterus must have been unduly weak. It is astonishing to see how much strain a healthy uterus can stand. In exemplification of one of the causes I have before mentioned, namely, unequal strain from a tumour, I will instance a case where labour had set in gently; but as time elapsed, and no advance was made, the medical men became anxious, and attempted to pass the short forceps, but unfortunately they were not long enough. No one possessed a long pair in the town, so turning was employed, and the child removed: but after this something came down which turned out to be fatty omentum. I was called in, and found a vertical rupture extending through the lower half of the uterus and part of vagina. The placenta being in the upper part of the uterus, I removed it and replaced the omentum, and brought together the edges of the rent, with intsructions not to move her. Now, at the time of my visit, which was four hours after the accident, she gave no sign that a lesion existed, neither in her aspect, nor in her pulse, nor as regards pain. But these arrived soon after, and she died next day. In my examination I found a fibroid in the wall of uterus low down, and a rather projecting sacrum. This case is an instance of the slight warning we often have of the occurrence of this formidable accident; for, on inquiry, there was nothing at any time which had led the attendants to think it had occurred; probably it began before version, and was increased by it. From the cases I have just narrated, you will observe how slight the early symptoms have been, and how deceptive the cases are. This has been the character of those cases which have occurred to me. It is seldom that one sees the class described in the older works on Midwifery, namely, *in a most violent pain, the organ suddenly gives* way with a feeling of tearing or cramp in the abdomen, and, as some narrate, with sound audible to bystanders. In these the symptoms which supervene are as follows:—a sudden cessation of the pains, a certain amount of recession of the presenting part, escape of hæmorrhage, generally not severe, from the vagina; collapse, *i.e.*, quick, thready pulse, pallor, anxious expression; and, shortly, coldness of extremities. If the fœtus has not passed through the rupture, then the recession will be within that of normal labour; but if it be more than half through, then the presentation will probably be if not out of reach, yet very nearly so. But the appearance of blood helps us little in dfagnosis, yet blood sometimes occurs somewhat freely on the full opening of the os uteri. But there are no symptoms of collapse with this. Yet collapse, as already shown, may be, and often is, absent.

However, when in the midst of a severe labour pain sudden abdominal pain arises, followed by free recession of the presenting part, escape of blood from vagina, and quickly collapse, we may be sure that we are in the presence of this fearful catastrophe. But what I want to impress on your mind is that we may have rupture of the uterus for many hours without any symptom, except the cessation of pains. But cessation of pains may occur with a perfectly safe labour. I have already brought this before you. How, then, are you to distinguish the two? In some cases it is very difficult at first, but a little care will, I think, detect a rising and failing pulse. Then if we find blood escaping and pain coming on in the uterus, we may begin to fear a rupture.

It is seldom, however, but what severe hæmorrhage is taking place, although not appearing externally. It escapes into the abdominal cavity or into the uterus. Of course it adds to the shock, so that there is both anæmia and nervous shock. Yet, as already noticed, many cases occur without any loss of importance.

The Dissecting-room.

Seldom, if ever, has the Dissecting-room been so well supplied with "subjects" as during the present session, and we hope to see, as a consequence, a corresponding increase in the number of successful candidates at the examinations which will take place in April. After the severe frosts at Christmas-time some fifteen or sixteen bodies accumulated, and were placed in the room underground; and the supply continuing to be large in proportion to the number of applicants for parts, our Demonstrator was compelled, about six weeks ago, to stop, for a time, any further delivery of subjects. Three weeks ago the supply was renewed, and on the same day five subjects were sent to us. Since then there has been again a gradual accumulation of bodies. The difficulties of obtaining a head and neck which always increases towards the close of the winter, is now being experienced by second year's men, owing to there being no applicants for the extremities. No similar delay occurs in the supply to first year's men, who obtain a body as soon as eight gentlemen are ready to dissect. Many first year's men are now dissecting their fourth part, and all ought to have dissected through the body before the close of the session. The second year's men have been divided into classes for the April and May examinations at the College of Surgeons, and appear to be working in a way likely to bring about a satisfactory result. The first written examination was held on Saturday last in the class-room of the Museum.

Mr. Charles J. Davey, M.R.C.S., L.S.A., of this Hospital, has been appointed (Feb. 1st) Out-door Assistant to the Sick Children's Hospital, Edinburgh.

A successful case of hyperprexia, treated with the cold pack, is reported in the *Lancet*. Waterproof sheeting was placed below the patient, and sheets wrung out of iced water were wrapped round the patient, and changed every five minutes. This was continued for fifty minutes, by which time the temperature (which at the commencement was 106·8 Fah.) had fallen to 99·6 Fah., and the patient was then put between blankets. The temperature continued to fall for the next twelve hours or so, when it was 96 Fah. This was noticed in each of the four cases which have recently been treated by the cold bath in our own wards.

Flatulent distension of the intestines is often found co-exsistent with a tumour in the abdominal cavity. The aortic plexus of the sympathetic supplies the intestines, hence a plausible explanation of this condition is that the tumour is pressing on the sympathetic, and producing paralysis of its nerves.

NOTES ON HISTOLOGY.

(From Dr. PYE-SMITH'S Demonstrations of Practical Physiology.)

(Continued from page 158.)

FOREIGN BODIES.—Dirt or moisture in the eye-piece or objective have been already mentioned. Moisture on the eye-glass is usually due to one's breath; on the objective, to allowing the cover-glass to be wet.

A greasy state of the cover-glass, generally produced by touching its surface with the fingers, is recognised by a more or less irregular faint pattern, which disappears on focussing down but leaves the field dim.

The glass slip itself may contain an air-bubble. This is recognised as a dark blurr, which, on focussing deeper than the object, turns into a broad black circle with a bright centre and more or less brilliant prismatic colours.

More frequent and troublesome are Air-bubbles in the water or salt solution, and especially in glycerine. They are due to greasiness of the cover-glass, or carelessness in putting it down, or to the fluid not reaching its edges. They are recognised by a clean black outline, which does not alter by focussing as long as it is visible. Moreover, though often round they also assume irregular shapes, and when squeezed by the cover-glass they alter their outline and run together.

Oil drops likewise depend on difference of refractive index between two fluids which will not mix. They are circular, and have a black outline and bright centre, like air-bubbles. But they do not assume irregular shapes, even when pressed upon; and, by focussing down, the black outline and central brightness disappear, and the drop looks a flat circular disk, with faint outline and a "greasy" usually somewhat yellow aspect. The first appearance is produced when the upper pole of the oil drop is in focus, the latter when its equator is: and the change of form shows that the oil forms a sphere.

Cotton, Linen, and Silk Fibres. The last are distinguished by smaller diameter, sharp outline, clean fracture, absence of marks and a bright polished appearance. Linen fibres are broader than silk and usually than cotton: they have a distinct but somewhat irregular outline, frayed ends, longitudinal markings and a dull "shaded" appearance. Cotton fibres are very similar, but usually rather narrower, and are distinguished by an additional central "midrib," and their tendency to twist. (The colour of all these fibres will, of course, depend on the dye of the fabric.)

Tea-leaves, fragments of Deal, and other vegetable foreign bodies will be examined separately. Infusorial animalcules are distinguished by their larger size, and the rapidity and irregularity of their movements.

MOLECULES.—It is convenient in Histology to define under this name all solid particles, from the smallest visible under the highest powers, which cannot be distinguished into parts and which exhibit Brunonian movement. Their characters, then, will be—minute size, absence of structure, and spontaneous movement. This remarkable phenomenon, exhibited by all sufficiently small solid particles when floating in a fluid in which they are not soluble, is named after its first observer, Dr. Robt. Brown, Professor of Botany in Glasgow. Distinguish it on the one hand from movements due to gravity, or to currents produced by evaporation, or to shaking of the table, and on the other from vital movement. It is a regular, oscillating, rapid to and fro gyration of each individual molecule. The only difference between molecules then—*structure* being absent, and this *function* common—will be size and *chemical* character. We may conveniently classify those met with in Histology thus:—

1. Albuminoid, containing nitrogen.
2. Oily (hydro-carbons).
3. Pigment (nitrogenous).
4. Earthy (insoluble inorganic salts).

Examples.—1. Contagious particles of the liquor puris of a pustule (Sanderson). 2. Molecular fatty degeneration of the heart. 3. Contents of epithelium of choroid. 4. Amorphous phosphates in urine. To see the Brunonian movement, take gamboge, pigment of bullock's eye, chalk, and add acid to the last.

GRANULES.—This term is conveniently applied to larger particles, the shape and parts of which can be seen, and which do not exhibit molecular movement. When *fluid* molecules, as oil, accumulate, they form drops with characters like those of an oil-drop given above. Aggregations of solid molecules are either crystalline or amorphous or intermediate (*e.g.*, "dumb bell crystals" of oxalate of lime), and will be recognised by their form, by their chemistry, or by both. Starch-granules, however, are not crystalline, nor are they nuclei or cells, yet they have a definite structure. Example—Potatoe: scrape the cut surface and examine in water with "inch" and then with "quarter." Notice their large size, oval shape (but varying like the size), clean outline, bright refraction, hilus, and concentric lines, with occasional radial splitting. Re-action: add iodine. View by polarised light. Compare with the starch granules of wheat and rice, and notice the small size and irregular angular shape of the last.

BACTERIUM CORPUSCLES—Examine under the highest powers you have a thin film of muscle-infusion, which has been exposed to the air at a moderate temperature. Notice the minute size of the bacteria, their oblong, rod-like shape, sharp outline, and absence of apparent structure. Next their zigzag, continuous movements, and the difference between this vital locomotion and the physical oscillation of molecules. Add potash: their cellulose wall protects them from dissolution. Beyond their vegetable character, origin from germs, destruction by heat, rapidity of reproduction and important place in the pathology of septic diseases, little is definitely known of the natural history of these remarkable organisms, and the allied forms called Micrococci, Vibriones, &c.

MR. T. PINK, M.R.C.S., has been appointed a Junior House Surgeon to the Royal Free Hospital.

AT the last meeting of the Council of the Royal College of Surgeons of England, Mr. John Hilton, F.R.S., late President of the College, and Senior Colsulting Surgeon to this hospital, resigned his seat as a member of the Court of Examiners, to which he was elected in 1865.

APROPOS of Jaborandi, which we mentioned recently, as having been given in our wards, we might mention that Dr. Ringer has found it produce profuse salivation and perspiration in about ten minutes. He has tried it somewhat extensively, and considers the proper dose for an adult is from 60 to 90 grains infused in boiling water.

DOES the sheath of the psoas muscle come into immediate relation with the pleura? No; but it lies sufficiently near to put us on the look out for inflammation of that lining membrane in cases of psoas abscess.

Operations.

Friday, Feb. 26.

Mr. Durham broke down the adhesions in a stiff elbow, operated on a fistula in ano, and made an incision in a cicatrix contracting after a burn.

Mr. Powell (Mr. Forster's dresser) removed a lipoma from between the shoulders of a patient in Charity Ward, and Mr. R. C. Richard (Mr. Forster's dresser) removed a recurrent epithelioma of five years' growth from the lip of a man, aged 50.

Tuesday, March 2.

Mr. Bryant performed colotomy on a youth, aged 19, from Accident Ward. Patient was the subject of a large cancerous growth, which was found on examination per rectum to occupy the whole of the pelvis, and which bulged forwards in the hypogastric region. The growth had been rapid and progressive, and pressed upon the bladder and rectum, interfering with their functions, so that his water was passed with difficulty and constantly, and his bowels had not been open for a fortnight. Mr. Bryant made the usual oblique incision, half-way between the last rib and the crest of the ilium. Some difficulty was at first experienced in bringing the colon to the wound, but this was overcome by tilting the body backwards. Mr. Bryant described the operation as one of expediency, to prolong life and make it more comfortable.

Mr. Bryant then sliced off a small epithelioma from the lip of a man, allowing the wound to granulate.

Mr. Lancaster (Mr. Birkett's dresser), by a V-shaped incision, excised a large epithelioma from the lower lip of a man in Lazarus Ward, and

Mr. Birkett then removed some necrosed bone from the arm of a boy in Lazarus Ward.

JUNIOR GUYITE CLUB.

A well-attended meeting of this Club was held on Tuesday, the 2nd inst., Mr. H. M. Powell in the chair.

The minutes of the last meeting having been confirmed, a ballot took place, which resulted in the election of the following gentlemen:—Messrs. C. E. Bell, Birdwood, Breach, Burt, A. Carey, W. J. Collington, Cusack, Edwards, D. T. Evans, Forty, A. W. Green, Griffiths, Harsant, Heddy, Instone, Jumeaux, Mason, G, Mackern, Mills, Paddison, Paley, Peyton, H. N. Smith, Stewart, R. Stanley Taylor, Wilding, and J. C. Wilkinson.

Considerable discussion ensued upon a proposal made by Mr. H. Duke, to empower the committee to elect members of the Club. An amendment was, however, carried which declared any alteration in the arrangements for the admission of candidates to be inexpedient.

Mr. Cock then proposed, and Mr. Morgan seconded, "That the committee be instructed to frame a code of rules for the Club, and to submit it to a general meeting for confirmation."

This was carried unanimously.

Mr. Moxon Turner made a few remarks upon the principles by which he considered members should be guided in the election of candidates, and the meeting then adjourned *sine die*.

HOW TO OBTAIN A SECTION OF THE RETINA.

(By C. J. Symonds.)

Any one who has tried knows how difficult it is to obtain a section of the retina. The ordinary method of simply hardening the posterior half of an ox's eye in spirit, and then cutting a section has two drawbacks.

1. The retina being very delicate, and not firmly attached to the choroid, and being unsupported on the inside (the vitreous being removed) falls into folds.

2. After it is hardened, though supported externally by the sclerotic, yet internally it is free, and readily separates from the choroid on attempting to cut a section from without inwards, and if the section is made from within outwards, the retina is dragged with the knife.

Another method is to remove a portion of the hardened retina, embed it in wax, and thus supported to make a section. This process would answer the second objection; but it is so difficult to handle a delicate structure like the retina, and to suspend it nicely, without injury, that this means is also objectionable.

To obviate these difficulties, I have adopted the following method for embedding, with success:—

Cut off the posterior half of an ox's eye, being careful to *retain* the corresponding portion of *vitreous humour*. Place it, just as it stands, into a vessel which fits it rather closely (as a wine glass) to keep the eye upright and maintain its form, containing a moderately strong solution of chromic acid. The vitreous supports the retina, and prevents it going into folds. During the hardening, the vitreous will tend to be drawn up to the centre, away from the retina; by placing a small weight, as a piece of a glass slide upon it, the vitreous will be kept in contact with the retina. After about six days' immersion, remove the shrinkled vitreous, when the retina will be found evenly in contact with the choroid. Drain out all the water, and run the cavity full of a mixture of wax and oil (3 to 1) just as it begins to set. This having hardened, remove the sclerotic from the choroid, being careful not to detach the latter from the retina. In cutting through the optic nerve a piece may be left to mark its situation. Dry the surface of the choroid, with filtering paper, squeezing the water from between it and the retina, and, having prepared a suitable amount of wax and oil, immerse the preparation in it, and allow it to cool. The sclerotic is removed, as it interferes with the cutting of a section, and retains moisture between it and the choroid, which prevents the wax setting closely.

Thus, the retina is embedded in a medium, that will cut with ease, and at the same time support the delicate structure. If the anterior part of the retina be desired, it will only be necessary to snip the sclerotic round on a level with the ciliary ligament, and removing the structures anterior to this point, to proceed as before. With this arrangement any one section may be depended upon, and the situation of the optic nerve being known, we shall be able to demonstrate the variations in the structure of the retina. The pathological condition of the retina can thus easily be studied.

The Physical Society will meet to-night, when Mr. W. Kidd will read a paper on "Purgatives." Mr. Waterhouse will occupy the chair

Sports.

FOOTBALL.

Inter-Hospital Challenge Cup.—Final Tie.

Last Wednesday the final tie between our men and the St. George's for the challenge cup was brought to a conclusion at Kennington Oval. For some days past the match has been looked forward to with great excitement, as the St. George's team were known to be in great form, and from the way that they disposed of the University men in their last trial match it was thought by many that they might prove very dangerous adversaries for Guy's, a very light match being expected by all. The day was cold, but very fine, the ground being in very fair condition, considering all circumstances. About 500 spectators were present, including two of our own staff, Mr. Cooper-Forster and Mr. Durham. Gray kicked off for Guy's at 3.30, Pinching having lost the toss. Aided by the strong wind in their favour, the St. George's men had slightly the advantage during the first half of the game, their forwards playing in very grand form, whilst the back play of Collins and Jennings was all thet could be desired. Although the ball was kept several times in dangerous proximity to their goal line, and the Guy's forwards played up with great spirit. The first touchdown soon succeeded by another, were scored in favour of St. George's. Till half-time was called the ball was kept well in the middle of the ground, as the tackling of the respective teams was too good for many fine runs on the parts of the backs, although Gray certainly carried off the palm all through the match in that respect. Goals being changed, with the wind in our favour, the game was carried on with immense spirit amidst the greatest excitement amongst the spectators; the cheers and counter-cheers for Guy's and St. George's being at times perfectly deafening. Till within twenty minutes of time nothing further had been scored, till the St. George's team worked the ball nearly on to our goal line. The game began to look almost hopeless for Guy's, but Pearson took the ball, ran and threw out from touch. He passeed all who attempted to collar him, and, taking his drop, obtained a touchdown for us, the ball being sharply followed by our men. Jennings for St. George's, dropped out, and the game, for a few minutes, was most evenly and desperately fought between the respective teams, till by a brilliant front by Gray, and good play by all the team, the ball was carried close up to the St. George's goal, and, amidst almost frantic excitement amongst the lookers-on, Mutch ran in for Guy's. The place was entrusted to Gray, who converted it into an excellent goal within five minutes of time. During that period the St. George's men played with great vigour, and once almost carried the ball on to our goal line, but when time was called it was at a safe distance from our goal. The match thus ended in our favour by a goal and one touchdown to two touchdowns, the result fully carried out the expectations of all who had witnessed the trial matches, whereas our men had slightly the advantage in the light scrimmages and back play, but the St. George's men had a decided superiority in the loose scrimmages.

The sides were composed as follows :—

Guy's.—W. Pinching (Captain), J. B. McClean and A. Finch (half-backs); W. E. Gray (three-quarter back), A. W. Pearson and J. T. Breach (backs); J. Rendall, H. Duke, H. Hetley, J. Osborn, P. E. Wallis, H. Welchman, P. F. Gilbert, J. Keer and L. Mutch (forwards).

St. George's.—W. E. Collins (Captain), and A. C. Lyne (half-backs); E. Jennings (three-quarter backs); C. M. Juke, H. M. Mackay (back); A. P. Sherwood, E. Hunt, H. A. Lighton, J. E. Mackinlay, E. L. Robinson, E. B. Turner, G. R. Turner, G. Walker, A, P. Young, and E. W. Young (forwards).

A match will be played, to-day, between the Selbourne Club and our Second Fifteen at Blackheath.

ARMY, NAVY, and INDIAN MEDICAL SERVICES.

The following questions were given at a recent examination of candidates for her Majesty's Army, Navy, and Indian Medical Services :—

Anatomy and Physiology.

Mr. Busk.

Monday, February 15th, 1875, from 10 a.m. to 1 p.m.

1. Describe the parts contained in the space circumscribed by four lines corresponding with the borders of the masseter muscle, in the order in which they are seen in a dissection from the surface to the mesial line.

2. Give the origin, course, and relations of the *profunda cervicis* artery, and the dissection required to display it on the posterior aspect of the vertebræ, noticing the parts exposed in the dissection.

3. Name the nerves by which the following muscles are supplied :—

Obturator externus:
,, internus.
Glutæus maximus.
Opponens pollicis.
Supinator radii longus.
Flexor longus digitorum.
,, ,, pollicis.

4. Describe the mechanism of the heart's action, the sounds attending it, and the causes to which they are assigned.

5. Give a general account of the lymphatic system, including the minute structure of the lymphatic vessels and glands.

6. Point out the distinctive characteristics of the male and female pelvis, and state the average dimensions for each outlet in the two sexes.

Surgery.

Mr. Pollock.

Monday, February 15th, 1875, from 2 to 5 p.m.

1. Describe the local and general symptoms of acute inflammation of the knee-joint, the result of an injury. What changes would occur in the external and internal tissues of the joint if the case progressed unfavourably? Describe the treatment in each condition.

2. State the symptoms by which an impacted fracture of the neck

of the thigh bone may be distinguished from fracture within the capsule without impaction,—and their treatment.

3. What character of tumour is usually found in the region of the parotid gland? Describe its structure; and the difficulties met with, at the time of, and subsequent to its removal.

4. State the most frequent causes of suppuration of the internal ear, its results, and complications; and treatment.

5. Describe the symptoms by which rheumatic iritis may be distinguished from syphilitic iritis; and the treatment of the latter.

6. A man has been wounded by a bayonet in the lower third of the inside of the thigh, the result of which is recurrent arteria hæmorrhage. Describe the treatment.

Medicine.

Dr. Parkes.

1. What is meant by the terms Pyrexia and Hyperpyrexia? How is the temperature of the human body best measured? How can the high temperature of Pyrexia be reduced?

2. What conditions of the heart may produce anasarca? Describe fully the cardiac physical signs, and give the treatment.

3. How is Ascites caused? Give the treatment in each case.

4. Give the symptoms and treatment of Diabetes Mellitus, and state what is known of its pathology.

5. How would you ascertain the existence of pregnancy? What is meant by the term "complicated labour"? How would you treat a case of foot presentation?

6. What medicines are supposed to act on the liver, and what are the reasons for supposing they do so act?

The Wards.

MEDICAL.

The following Cases were admitted between Feb. 26 and March 3:—

ADDISON—6—Obesity. 8—(?) Anorexia 18—Phthisis.

JOHN—5—Typhoid—diphtheritic throat. 8—Pneumonia. 15—Icthyosis—ventral hernia. Cot—Hemiplegia.

BRIGHT—11—Jaundice. 28—Acute rheumatism.

PHILIP—1—Locomotor ataxy. 12—Pleuritic effusion (left). 18—Phthisis—morbus cordis. 25—Phthisis. 30—Pleurodynia. 34—Bronchitis—emphysema. 49—Phthisis (?).

MIRIAM—23—Morbus cordis. 26—Cerebral Siphilitic. '30—Carcinoma (?)

MARY—1—Bronchitis. 2—Hysterical mania. 3—Morbus cordis. 5—Hysteria. 9—Rheumatism. 17—Pleuritic affection. 12—Diarrhœa. 21—Phthisis.

STEPHEN—2—Acute rheumatism. 3—Aortic disease. 21—Mitral regurgitation. 31—Cerebral. 35—Acute rheumatism. 38—Sclerosis 40—General paralysis. 50—General paralysis.

SURGICAL.

Mr. H. Powel Dresser for the week

ACCIDENT—Fractered femur. Fractured tibia and fibula.

CORNELIUS—1—Fractured fibula and tibia. 3—Fractured tibia. 6—Crushed toe—amputation. 10—Bruise of shoulder and hip. 11—Fractured clavicle and ribs. 12—Compound fracture of tibia and fibula. 17—Fractured fibula.

LAZARUS—Chronic eczema of leg—lymphatic inflammation. Necrosis of femur.

JOB—Disease of knee-joint.

LUKE—3—Disease of knee. 5—Strangulated inguinal hernia: 8—Disease of os calcis: 7—Fistula, 9—Old carbuncle. 12—Stricture—villous disease of bladder. 14—Stricturc. 15—Epithelioma of lip. 18—Fistula. 21—Disease of knee.

NAAMAN—Amputation of finger. Axillary abscess.

MARTHA—Effusion into bursa patellæ. Loose cartilage of knee.

LYDIA—Fractured femur. Morbus coxæ. Necrosis of tibia. Synovitis of knee.

DORCAS—Hæmorrhoids. Nævus.

CHARITY—3—Injury to face. 6—Strangulated femoral hernia. 9—Abscess of rectum. 11—Ranula. 12—Fractured tibia and fibula. 14—Dog-bite. 14—Burn. 16—Fractured tibia and fibula. 17—Fractured patella. 18—Lipoma—anchylosis of shoulder-joint: 19—Inflamed bursa patella. Crib—Fractured femur.

APPOINTMENTS.

The following gentlemen are in residence at the Hospital during the present month:—

House Physicians, Messrs. Paul and Fry.

House Surgeon, Mr. H. Williams.

Senior in the Charity, Mr. T. S. Morley.

Junior in the Charity, Mr. D. B. Lees.

Mr. H. Clarke is Junior House-Physician, and Mr. D. Forty, Junior House-Surgeon.

HOSPITAL SUNDAY FUND.—The annual meeting in connection with the Hospital Sunday Fund will be held in the Mansion House on Monday, the 8th inst., at three o'clock. As it is believed there will be an attempt on the part of certain representatives of the most obnoxious class of special hospitals to repeat the disgraceful scenes which were witnessed at the last general meeting, all supporters of the principle of fair distribution, as explained in the Report of the late Distribution Committee, are earnestly requested to attend.

RESEARCHES ON "LIGHT."—Dr. Mackendrick and James Steward, F.R., S.E., have received a grant of £150 from the British Association for their researches on the "Action of Light."

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LECTURES ON PATHOLOGICAL ANATOMY.

BY SAMUEL WILKS, M.D., F.R.S.,
Physician to, and Lecturer on Medicine at, Guy's Hospital; and

WALTER MOXON, M.D., F.R.C.P.,
Physician to, and late Lecturer on Pathology at, Guy's Hospital.

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"WHAT we want to acquire," said Dr. MOXON, in his Clinical Lecture on Saturday last, "is that greatest of all powers, seeing things prominent according to their importance." And truly nothing can he more essential than, from among the multiplicity of symptoms which a patient complains of, to be able to pick out those which really have reference to the disease from which he is suffering, and the difficulty of this is not the less increased from the fact that the patient himself frequently lays most stress upon trifling symptoms—often only subjective—which he imagines to be of great importance, to the comparative neglect of those points upon which the diagnosis will mainly have to be founded. In order to obtain and educate this power there cannot be a question but that the wards are of far greater value than books. Few men who have worked any length of time in both can help being struck with the fact that the symptoms of disease, as given in the books, are not the symptoms by which the case is diagnosed in the wards; or, to put it perhaps more exactly, the greater stress is laid upon different points in the two cases. Take, for example, the subject of Peritonitis. The symptoms of this disease, as we gather from our authors, are mainly:—Feverishness, great abdominal pain, and tenderness, small wiry, hard, frequent pulse, and dorsal decrepitus, with the legs drawn up. Now, what are the points on which we rely to make our diagnosis in the ward? Dr. Moxon, in a Clinical Lecture on this subject last year, arranged the three main symptoms in the following order of value:—1st. Tympanitis; 2nd, Tenderness; and 3rd, Hypocratic expression; and we must all recognise the truth of this sequence. But of these three symptoms only one—the tenderness—is mentioned by so high an authority as AITKEN. The Post-mortem Room constantly shows us Peritonitis without there having been any pain before death to lead to a suspicion of its presence. The pyrexia is generally slight, and frequently absent, the pulse is accounted now of comparatively slight value; and it is the exception rather than the rule to see a patient lying with his legs flexed. The best way, undoubtedly, to avoid being confused by the number and variety of the patients' symptoms is to keep the few broad facts of each disease closely impressed upon the mind, and to try and follow out a certain line of reasoning in each case. In seeing a patient for the first time with Pyrexia how it simplifies the case to remember, as Dr. WILKS is so often telling us, that it can only be due to one of four things; a local inflammation, a specific disease, tubercle, or pyæmia. "What is it?" said Dr. MOXON, speaking of Typhoid Fever, in his Clinical Lecture. "Shivering, headache, pains in the limbs, prostration, and high temperature, all of which may be included under the term Pyrexia, and because it lasts for some time we call it continuous. First, then, continuous pyrexia; next, no sufficient explanatory disease; and lastly, diarrhœa, or disturbance canal of some kind." What a simple but graphic picture of the Fever does this description give us. How easy to remember, but how important in such a "multiform" disease as Typhoid to have such a photograph as

this impressed on the mind; "for if," he goes on to say, "in *any* case, during the first five or six days, you find these features brought out, you are justified in thinking the case is one of Typhoid Fever." "Fine crepitation, and rusty sputa," remarks Dr. Wilks, "are pathognomonic of Pneumonia," but how often do we find students describe symptoms innumerable in reference to the man's chest, but never think of looking at the contents of the porringer. We might multiply such examples to almost any extent, but the moral in all is evidently the same—that we should endeavour by constant attendance in the wards to obtain a knowledge of the relative importance of symptoms, to be able to eliminate those which have little or no reference to the disease, and to lay the greater stress on those which will lead us to the correct diagnosis. And there can be little doubt here, that note-taking is of the greatest value. It is, we have often thought, surprising how many students trust to their memory in that respect, and how few commit to paper the points of the case as brought out by the physician. If a student were to constantly take notes in the wards, and methodise them when at home, he would at the end of four years possess a treatise on Medicine which must ever after prove to him invaluable. Every statement would have the authority of men of the largest experience, and every symptom described would bring before his mind the case he had seen under treatment.

A STUDENT'S NOTES OF

Lectures on Midwifery.

By J. Braxton Hicks, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

Lecture XVIII.

Rupture of the Uterus (*continued*)—Supposing, then, you have every reason to believe that the uterus is ruptured, what are you to do? Consider one point first. If you leave the case alone, will the uterus attempt to resume its contractions? Of course it is impossible to answer this question, because as soon as it does the rent, if small, is extended, and if already large, the child has slipped out of its grasp. It is clear, then, that there is no advantage in waiting, because if the rent be small, it may become large. But is there any disadvantage in rapidly delivering? May not the empty inert uterus be left with all the dangers I have before pointed out. You *may* have that condition of uterus, but generally the condition of collapse is sufficiently severe to check a serious loss. If the rent be great and the uterus have withdrawn itself from the child, then the closure of the sinuses are generally secured by the passive contraction of the uterus. Practically I have not met with any hæmorrhage upon removal of the placenta. Our rule is, then, deliver as early as possible, but not with undue haste.

But by what means? If the head be within reach, by the forceps, unless there be a known obstacle which will require perforation, in which case, of course, by perforation and some traction after. If the os uteri be not fully dilated, delivery by perforation and craniotomy was the plan recommended; but now we are in possession of dilators, I think these would open the way for the forceps, with less total disturbance than with perforation, and the craniotomy forceps and crochet. However, time may be important and the bags may be absent, so that much must depend upon possibilities. You will easily perceive that our object is to abstract the fœtus early, and with the least disturbance to the parts; if, therefore we, in inserting the forceps, perforator, &c., press back the child with force, or rotate violently from side to side, we shall be doing more or less harm, you should, therefore, in all cases place the hand externally on the abdomen to support the fœtus, and this with the least possible amount of agitation. Nor should you move the patient, as advised to do generally before midwifery operations, to the edge of the bed, but you must learn how to do that which is required as she lay; and with regard to the long forceps the upper blade must, as I shall show you later on, be carried up the general curve, and gradually move forwards into the transverse diameter of pelvis, by which the disadvantage of the length of the handle is avoided. By whatever means you abstract the fœtus, it should be done with the utmost steadiness, and unless you are certain the child is wholly in the uterus, I should advise you not to use external pressure, support it at the most, but do not indent it by the hand. Even if the child have not escaped through the rents, external pressure may tend to increase the rent.

But what are we to do when we fail to reach the head, or if we do, we can but just touch it?

We may conclude that it has passed wholly or in part through the rent. If still we can reach the head, another effort may be made to bring it down. The hand passed up to grasp it, or a whalebone fillet passed over the child might secure it, or we may employ the forceps. If the breech, knee, or foot present, then this must be seized by finger or blunt hook, and gently drawn down. If under these circumstances the head have passed through the rent, when it is again drawn through, unless the uterus be quite relaxed and the rent large, then in your withdrawing it, the head may be caught in the opening and a liability to invert the uterus will occur. Therefore, if any resistance occur to our traction we must proceed cautiously, and pass our hand up as far as possible, to endeavour to push the edges of the rent over the several projections of the head, and in like manner if the shoulders should have become caught, the same plan must be adopted, whether the head or pelvix present.

But if we find in our examination that the child has nearly or quite passed into the peritoneal cavity, then we have three courses open to our selection; first, to pass the hand through the rent, seeking and seizing the feet, bring the child through it, and out through the natural passage. This has been done, and successfully in many cases. But you can readily see what amount of displacement must be caused, and even you can understand how that the rent may be increased, and the uterus damaged still more.

Yet you must compare the other plans at command, which brings me to the second course, namely, to leave the fœtus in the abdominal cavity. If any small part remain in uterus, then this must be pushed entirely through, and with regard to the placenta, it should either be pushed in after it; or the funis severed by the thumb nail, and then after a few minutes waiting for the bleeding to cease, it can be pushed through the rent. Of course a certain amount of peritonitis will arise, and it may be sufficient to kill a patient, particularly if the fœtus tend to putridity; but most generally the fœtus does not undergo this kind of decomposition, but the plastic effusion is poured out all round it and its neighbourhood, whereby it is enclosed in an adventitious cavity, and thus shut off from the rest of the abdomen, where it may remain dormant for years, yet at any time it may set up irritation and suppuration, and there will be endeavours to find an escape in various ways, through the abdominal parietes, through the rectum and bladder. If the patient be strong, she may survive, but the chances are much against her, for although the smaller bones may come away readily, yet the larger, as the femur, or more particularly the cranial bones, will require a large opening. The flat parietal may, however, be seized by a long and strong polypus forceps, and after a manner be rolled up into a cylindrical form, of course with care.

The third plan we may adopt will be to push the child wholly within the abdomen, and then to perform gastrotomy. If the case occur to ourselves, I think this is better than the second plan, and better than bringing the child again through the rent, if any difficulty occur to finding the child's legs. If, however, we have been called some time after, and peritonitis have already commenced, then perhaps it will be best to leave the case to Nature. After the removal of the fœtus and placenta, we should very carefully sponge out every portion of blood, draw out any coils of intestine, or omentum, &c., which may have passed through the rent into the uterus. The same rule should obtain after removal of the fœtus by the natural passages acting from within. A case has occurred fatally from the incarceration of a small knuckle of intestine in the rent.

The closure of the edges of the uterine rent after gastrotomy may be done by stitches, as recommended in Cæsarian section, but opinions are divided on the subject. In any case it is needful to keep the os uteri clear for the escape of discharges. In any case where we have rupture or even suspect its having taken place, it is an imperative rule to keep the patient motionless, the bowels restrained by opium for ten days or a fortnight, after which time the bowels may be permitted to act and slight movements allowed.

Physical Society.

At the meeting of this society, held on Saturday last, Mr. Waterhouse presiding, a paper was read by Mr. Kidd on "Purgatives," of which the following is an abstract:—

Purgative medicines were defined, and reference was made to the unsatisfactory state of their classification. They acted primarily on the intestines, and secondarily, through them, on other parts of the system. Before proceeding to the consideration of their action in general, the subject of cholagogue purgatives was discussed. Cholagogue purgatives, so-called and mercury especially had long been considered to increase the flow of bile from the liver; this was shown not to be the case a few years ago by a Committee of the British Medical Association; mercury in large doses diminishing the quantity of bile formed. Similarly podophyllum and taraxacum were shown to be inert. Mercury did increase the quantity of bile in the fæces; this was to be accounted for by its acting on the upper part of the intestines as a purgative, so hurrying on the bile poured out, and causing it to be evacuated, thus bile would normally have been re-absorbed to a considerable extent for further use.

Purgative *medicines acted in two ways*—1st, by *increasing peristaltic* action; 2nd, by increasing the secretion from the walls of the intestines.

The view lately proposed, viz., that all Purgatives act alone by increasing peristaltic action was discussed, and arguments and experiments were put forward in favour of it; but recent experiments by Moreau and others were quoted, also some further considerations which seemed altogether to disprove this theory, so that Purgatives were still maintained to act in the two ways before-mentioned.

Reference was made to those Purgatives which act merely as local irritants, and contrasted with those which purge even when injected into a vein. The effects of these two actions of Purgatives were then noticed; first the counter-irritant effect, as seen in the case of aloes, used in amenorrhœa; next the manner in which they remove fluid from different parts of the body in dropsy; then their simple and obvious effect of causing food to be passed along the alimentary canal before it has had time to be sufficiently acted upon by the different digestive fluids, producing the same result, as if a smaller quantity of food had been taken, i.e., of course if the purgative had been taken soon after the food. The injurious result which might follow the administration of purgatives for a long period, and at improper hours, especially those purgatives which act on the upper part of the intestine, was pointed out; this would depend on two effects—1st, the food being hurried along too quickly to allow a sufficient quantity to be absorbed for nutrition; 2nd, the excess of gastric and pancreatic juices and of bile, which ought normally to be absorbed for further use is lost by being evacuated from the body, thus indigestion would be impaired. Administration of purgatives in inflammation of any part of the body was then spoken of; *they are in practice found useful in some forms* of inflammation, but not in all; their action in inflammation was considered to be due to their lessening vascular tension; they acted similarly to bleeding, but had not the same weakening effect.

Constipation was next discussed, and the employment of Purgatives in this condition. In certain forms of constipation all were agreed that Purgatives were necessary, but a clear distinction was to be made between the forms of constipation in this matter, and the treatment of all forms of constipation alike with purgatives was deprecated. Some forms, such as the constipation of young people, otherwise healthy, and of those debilitated in health were better treated and more rationally, by regulation of habits of life and diet, the importance of brown bread being spoken of. The great value of nux vomica and of belladonna in some obstinate cases was indicated. The constipation of colic was best treated with castor and croton oils, opium being also given. The dropsy of Bright's disease and heart disease often benefitted much by the administration of hydronogue purgatives, especially the former. The benefit of purgatives in kidney affections due to two effects which they produce—1st, diminish the work which the kidney has to do by causing a drain from the bowels. Secondly, diminish congestion of kidney and prevent interference with its functions, elaterium being found sometimes to lessen or remove albumen from urine; they also increased the activity of diuretics.

In *certain forms of jaundice and some conditions of liver aperients were* useful. In some diseases of the brain constipation was a marked symptom, and purgatives were very useful; there appears to be some curious connection between the intestines and the brain shown in several ways, as for instance the remarkable feeling of fulness in the head in constipation Other instances were pointed out.

The paper concluded with a reference to those conditions in which Purgatives were either unnecessary or injurious.

The discussion was opened by Mr. Symonds, who said they seemed to give purgatives on two main principles—1st, merely to unload the bowels, and 2nd, to affect the system generally, as in affections of the brain and dropsy. In ordering them in the latter disease, especially if the drug were elaterium, they must be careful not to go too far as enteritis might be set up. They must be very careful also in the use of purgatives, for the constipation arising after fevers. People could not now stand the same amount of purgation as formerly, probably owing to the difference in the mode of living and diet, and to the great tension and high pressure at which we were living. If some tonic, as nux vomica, were combined with the purgatives, it would prevent the constipation so often following their use.

Mr. Fry had hoped Mr. Kidd would have brought forward more purgatives, and shown which were most useful in the different complaints. In a case of colic, under Dr.

Habershon, a grain of opium was combined with a drop of croton oil. He described the case of a man who fell down in a fit, and was brought to the hospital unconscious; he remained unconscious for some two hours, was then carried into the strong room, and two drops of croton oil given. This being insufficient, a second dose followed, and an enema of soap. That acted tolerably well, and he afterwards fell asleep and awoke quite calm.

Mr. HARSANT was much interested in the paper, as in these days of pathology we were too apt to neglect therapeutics. Especially was the first part—on the action of mercury—interesting. Although formerly supposed to increase the amount of bile, it was now found to have the opposite effect. It really acted by causing an increased peristaltic action of the small intestine, especially the duodenum. In "biliousness" too much bile got into the blood, and the effect of mercury then was to cause the bile to flow on and become evacuated. He thought we could stand purgatives now as well as formerly. Formerly it used to be the habit whenever a man was ill to give purgatives, and a great many patients were killed in that way.

Mr. COLEY agreed with Mr. Kidd that hydro-cathartics increased the intestinal secretions. If bitartrate of potash were given alone it would produce a copious secretion of fluid into the alimentary canal, which might subsequently be absorbed, unless something were added to stimulate the muscular fibre, and cause its expulsion. He could scarcely think it made much difference whether the secretion was increased or the intestines stimulated as far as the tension in the blood-vessels was concerned; because an equal quantity was removed in either case. He agreed with Mr. Symonds that we did not bear purgatives so well as the former generation. The long-continued use of purgatives of almost every class produced a state of intestine which did not easily respond to any stimulus, natural or artificial. Habitual constipation could not continue any length of time without producing harm, both affecting the general state of the constitution, and producing local troubles, as hæmorrhoids. At the same time it was necessary to avoid the continued use of purgatives if possible. The treatment must be rather hygienic measures and proper diet.

Mr. ELCUM described a case in Addison Ward of heart disease, anasarca and albuminuria. Pulv. Jalapæ Co. was ordered, five grains at a time. The albumen very much lessened, and the anasarca disappeared. Purgatives were remarkably unequal in their action, sometimes very violent, at others almost inert. He had once taken ten grains himself, and found it have no effect whatever, but on another occasion he took the same dose, and the effects were better imagined than described.

Mr. DUKE wished Mr. Kidd had paid more attention to natural purgatives, as the "bile." Men were not so subject to constipation as the other sex were, due probably to greater amount of exercise taken by them, causing a greater increase in the functions of the liver. He quite agreed with Mr. Coley, that purgatives should not be continued for too long a time.

Mr. J. MCKERN in speaking of natural purgatives, thought the best thing was to keep the liver in proper action.

Mr. G. MCKERN remarked that Mr. Kidd had not said whether purgatives acted in a topical way or were absorbed into the system. He, himself, thought they acted largely upon the sympathetic system, their topical action might be due to direct irritation of the nervous plexuses between the coats of the intestine.

Mr. Davy thought that in case of lead poisoning it was most useful to give purgatives as well as iodide of potassium, because it helped to eliminate the lead from the system. The experiments on animals described, were very unnatural, the perforation of the intestine would probably have a great deal to do with the increased flow into the middle loop.

Mr. SHADWELL had no doubt that when a purgative was given there was a large increase of fluid. If they remembered the natural condition, how the fluid taken was first absorbed and then again poured out, this process going on throughout the whole intestine, it was not difficult to understand that if the peristaltic action were increased, there would not be time for the fluid to get absorbed, and, therefore, they got an increased evacuation. Habitual constipation was often due to the want of fluid, and the habit of taking a glass of cold water every day, was found in a great many cases to overcome the difficulty.

Mr. MORLEY in speaking of the chronic constipation of females, described a case of Dr. Moxon's, where the constant current was applied, to the great relief of the patient. This would suggest that the proper mode of treatment in such cases was to endeavour to restore the tone of the intestinal wall. It was very difficult to know what combinations to use, on account of personal idiosyncracy. He asked, in conclusion, what was the best purgative to use when the intestines were very much loaded with scybala, and there was a question as to the existence of a tumour. Dr. Lees had recommended mist. mucilaginosa with sulphate of magnesia.

Mr. KIDD then replied, and after the usual vote of thanks, the meeting adjourned.

The last meeting of the Physical Society will be held on Saturday next, the 20th inst. Mr. E. Cock, the Honerary President, will take the chair, and Mr. R. E. Carrington will read a paper, entitled "The Physiological Action of Alcohol." At the close of the meeting the report of the Presidents will be read, giving the names of the successful competitors for the prizes. It is hoped that the attendance will be good.

THE CHILDREN'S HOSPITAL, BOSTON, MASSACHUSETTS, U.S.

(By our correspondent in America.)

The Children's Hospital, Massachusetts, U.S., is No. 1429, Washington Street. The road there is wide and lined on both sides with trees. The hospital was once a private dwelling-house, and is built of brick; the foliage in front gives it a picturesque appearance.

A flight of stone steps leads to the front door, which is covered in with a porch. The ground-floor and basement are devoted to the administration: the first and second floors, divided each into three or four rooms, some of which communicate, are used as the children's wards; the attics serve as bedrooms for the servants.

The rooms on the ground-floor are, first, a reception-room for visitors: second, a nurses' bedroom; third, a

nurses' dining-room; part of these rooms, extending further back than the above, afford, by their roof, an out-door space, covered in with canvas, where the children take the fresh air in warm weather. Some of the wards are decorated with creeping plants, growing from the window-sill and climbing up the corners and the cornices.

The hospital accommodates about thirty patients, three or four in each ward; the bedsteads have easy springs, and moveable sides with hinges, each has a bed-tray also. (The best hospital beds I have yet seen are the woven wire mattresses, made at Hartford, Conn., U.S, bedstead complete, price £3 10s.)

Dr. Francis H. Brown, one of the original founders of the hospital, and the lady superintendent, Sister Theresa, are pleased with their success in assimilating it to the Children's Hospitals in London.

The nursing is done by ladies of the Sisterhood of St. Margaret. There are three physicians and three surgeons, one of each acting in rotation every four months; there is also an assistant, Dr. Homans, who courteously showed me over the hospital.

He pointed out to me three or four cases of hip-joint disease, treated by extension and rest, two of white swelling of the knee, in which he was about to apply ice, a case or two of eczema capitis, some strumous abscesses, and a little Newfoundland child, who was suffering from some chronic ostitis of the finger bones, possibly rickety; one or two of the fingers had been amputated. The Children's Hospital at Boston was founded about five years since by private charity directed into a special channel by professional men associated with laymen. Thus originate, from time to time, in various places, special hospitals for the study and treatment of children's diseases. They deserve all the support they obtain, for the children are happier together, as any one knows who has ever been from a drawing-room into a nursery.

It would be well if there was a children's ward in every general hospital, large or small. It would be a benefit not only for the children themselves, but for the other patients also; for the nurses, who require to be more careful, gentle, and cheerful; and for the students, who generally learn things more easily when they are presented to him in the aggregate than when they occur fortuitously and unfrequently.

I. R. S.

The Surgery.

During the past week two cases of compound dislocation of the ungual phalanx of the thumb have occurred amongst the patients seen at the Surgery. The first occurred in a man aged 55. On March 3rd he fell down, bending his right hand under him, and causing a backward dislocation of the terminal phalanx of his right thumb, the head of the first phalanx protruding through a wound on the palmar surface of the thumb. He came to Guy's on March 4. After repeated attempts had been made at reduction without success, chloroform was given, and the displaced bone restored to its normal position, but only after much forcing had been used.

The second case was that of a young man, aged 22, who had a blow on thee nd of his extended thumb. In this case also the terminal phalanx was dislocated backwards and the head of the first phalanx protruded through a wound on the palmar surface of the thumb. In this instance reduction was effected without chloroform by forcible extension, the phalanx being held firmly with padded nippers.

These causes will serve to show the great difficulty which is often met with in reducing these, apparently simple, dislocations. In the first case, forcible extension, backward flexion and manipulation, were tried for some time without success, both before and after the patient was anæsthetised, and it was only after much force had been used that the displacement was remedied.

In the second, forcible extension without chloroform proved sufficient. With regard to the treatment, supposing that it is found impossible to reduce the dislocation, the question arises whether it would be better to excise the head of the proximal phalanx (or metacarpal bone, as the case may be), or to leave the bones in their abnormal position. We think that the preference must be decidedly given to the former course, for by it one considerable source of irritation will be removed, and in all probability a better thumb will be left, as a moveable joint may be fairly expected after excision of the head of the proximal bone.

In addition to the above several interesting cases of injury to the shoulder-joint have occurred.

I. A. H., aged 40. Sub-glenoid dislocation of the humerus of five weeks' standing; this case was admitted into the hospital, and an unsuccessful attempt at reduction made. The patient is still in Job Ward.

II. T. R., aged 62, female. Sub-glenoid dislocation of humerus. Recent. This was reduced by manipulation. The scapula was fixed from behind by the fingers of the left hand, the thumb being used as a fulcrum in the axilla, extension was made from the elbow, and on the arm being brought down to the side of the body, the head of the bone slipped into its proper position.

III. Sub-glenoid dislocation in a man, aged 41. This was a very well marked case, the principal points being—1. Prominence of the acromion, with very marked depression beneath it, and loss of the roundness of the joint. 2. The position of the arm, which was abducted, the elbow being carried some distance from the side, the patient having no power to bring the elbow into contact with his side. 3. Loss of power in the arm. 4. Pain. 5. Increase in the depth of the anterior axillary boundary, and increase of 1½in. in the vertical circumference of the shoulder. 6. Pressure of the head of the bone in the axilla, which moved with the shaft without any feeling of crepitus. In this case reduction was effected by extension with the heel in the axilla.

IV. Sub-coracoid dislocation of the humerus in a woman.

In addition to these cases there was one of separation of the epiphysis of the upper end of the humerus in a boy aged seven years. And one case of fracture through the glenoid cavity of the scapula in an old man, aged 66. This accident was caused by a fall upon the shoulder.

At a General Court of the Governors of the Hospital, held on Wednesday last, the Treasurer in the chair, the Right Hon. Lord Lawrence was elected President of the Hospital, in the room of the late Mr. John Gurney Hoare.

Operations.

Friday, March 5.

Mr. Forster operated for necrosis of the lower end of the femur. The patient was a boy of about 18 years of age, who was in the hospital sixteen months ago. He had received a blow, causing effusion into the knee, this subsided, and he left the hospital, but returned a short time since with considerable effusion into the joint, ostitis around the lower end of the femur, and a sinus in which dead bone could be felt and from which a few pieces had come away a few days previously. Mr. Forster cut down on the bone, and found it located behind the joint, but he was unable to remove it.

Mr. Durham operated for fistula.

Mr. Burton (Mr. Durham's dresseer) performed circumcision for incontinence of urine in a child. The operation has cured this condition.

Mr. Bryant attempted the reduction of a sub-glenoid dislocation of the humerus of five weeks' standing, and, though various modes of reduction were adopted, no alteration in the position of the bone was effected.

Sunday, March 7.

Mr. Bryant operated on two cases. The first was an umbilical hernia, strangulated for over thirty hours. It was of immense size, very hard, and the skin discoloured in parts. The bowel was black and so rotten that two or three openings were found during the operation, and they contained a quantity of offensive black fluid. The abdominal opening was freely divided, but the sac itself was not much opened, and the intestine was not returned; one omental band was discovered. The woman died the next night.

The second case was a boy, aged 9 years. He struck his perinæum on the edge of a board while getting out of bed at 8 a.m., and was unable to pass his water till 10 a.m., when he passed blood with it. There was much swelling, and some ecchymosis of the perinæum. A catheter would not pass more than three inches down the urethra. Mr. Bryant then cut into the perinæum on a grooved staff, and endeavoured to find the posterior part of the urethra, with the view of stitching it to the anterior, but he was unsuccessful, so the boy was sent to bed as he was.

Tuesday, March 9.

Mr. Birkett amputated the leg of a woman from Martha Ward, at the junction of the upper and middle third. The patient was admitted just after Christmas last, with compound Pott's fracture. Phlegmonous erysipelas set in, and was treated by free incision. No union took place between the bones, and there being great displacement of the foot outwards, due to the difficulty of maintaining the position during the erysipelas, Mr. Birkett resolved on amputation. Lateral flaps were made.

Mr. Bryant performed excision of the hip for morbus coxæ. Some dead bone was removed from the bottom of the acetabulum. The same operator removed some necrosed bone from the leg of a patient.

Mr. Durham operated on a boy, both of whose legs had been amputated through the lower end of the middle third of femur last August, in consequence of an accident. He had made a good recovery, but the flaps, which were made long at the time, retracted, and this, together with increase of length of femur at the superior epiphysis, induced a conical condition of the stumps. Mr. Durham was, therefore, led to resect both femora, which he did by making incisions over the ends of the bones, thereby removing the cicatrix and baring the bone. The tissues were then dissected up, and about two inches of the end of each femur removed. A portion of bone was found necrosed in one.

Wednesday, March 10.

Mr. Durham reduced a strangulated femoral hernia, under chloroform, and cauterised a part of a hairy nævus on a child, by the galvanic cautery.

The Wards.

The following Cases were admitted between March 4 and March 10

MEDICAL.

Addrson—1—Phthisis. 4—Acute rheumatism. 8—Acute rheumatism. 14—Phthisis. 19—Hæmoptysis. 23—Chorea.

Bright—5—Debility. 7—Chlorosis. 13—Chorea—mitral regurgitation.

Philip—5—Bronchitis—mitral regurgitation. 9—Cirrhosis—Ascites—Bronchitis. 18—Bronchitis. 22—Rheumatism. 24—Rheumatism. 33—Diabetes.

Stephen—9—Morbus Cordis. 10—Typhoid Fever. 13—Diabetes 24—Bronchitis and Emphysema. 33—Peri-typhlitis. 36—Phthisis. 38—Phthisis.

Mary—1—Bronchitis. 12—Mania. 24—Phthisis. 31—Epithelioma 36—Ovarian disease. 38—Epithelioma. 40—Anteflexion.

John—2—Empyma with morbus Brightii. 5—Acute Pneumonia right apex.

Miriam—19—Hysteria—Catalepsy. 28—Morbus cordis. 31—Morbus cordis. Cot—Croup—Tracheotomy—death. Cot—Bronchopneumonia.

SURGICAL.

Mr. Hobson Dresser for the week.

Accident—3—Crushed fingers. 4—Fractured tibia and fibula. 15—Fractured tibia and fibula. 21—Fractured neck of femur. 25—Incarcerated femoral hernia. 27—Concussion of brain. 28—Inguina hernia (reduced). 31—Run over abdomen; peritonitis.

Lydia—2—Malignant polypus of antrum. 3—Ulcer of leg. 4—Fractured ribs. 10—Strangulated umbilical hernia. 19—Necrosis of tibia. 24(cot)—Wound of leg.

Martha—8—Ulcer of leg. 14—Inflamed bursa patella.

Dorcas—11—Strangulated femoral hernia. 16—Lipoma. 22—Malignant disease of axillary glands. 27(cot)—Necrosis of humerus.

CHARITY—6—Necrosis of toe.

LAZARUS—4—Fistula. 7—Carbuncle. Stricture of rectum.

JOB—7—Stragulated inguinal hernia.

LUKE—11—Stricture. 8—Disease of knee-joint. 13—Enlarged Prostate.

NAAMAN—11—Stricture. 18—Abscess of abdominal wall (?).

APPOINTMENTS.

The following appointments have been made in addition to those published in a recent number :—

DRESSERS IN THE SURGERY—
Messrs. R. A. H. Hart, F. T. Milne, J. G. Harries and A. Pain.

POST-MORTEM CLERK—
Mr. J. C. Wilkinson.

AURAL SURGEON'S DRESSERS—
Messrs. G. Davis and T. A. Richardson.

ASSISTANT SURGEON'S DRESSERS—
Messrs. F. T. Wilkinson and G. B. Messum.

DENTAL SURGEON'S DRESSER—
Mr. J. Todd.

SURGICAL WARD CLERKS—
Messrs. Thos. Dutton and A. G. Wells.

Extracts.

(From the *Sanitary Record.*)

THE EFFECT OF BITCHES' MILK UPON RACHITIC INFANTS.—A curious fact was mentioned by Dr. Bernard at the late meeting of the French Society for the Protection of Infant Life, and is reported in the *Journal de Medecine et de Chirurgie* of March. In the Commune of the Drôme, at Montbrun-les-Bains, the women are in the custom of protracting the nursing of their chlidren until the age of two and a half to three years, and all women who lose their nursling before this period has arrived, substitute a young puppy. Now these pups become rapidly rachitic and remain deformed, unless they are returned in good season to the milk of their mothers. This fact is well known to many physicians. Dr. Bernard conceived the idea of subjecting an infant, twenty-six months of age and exceedingly rachitic, to the use of the milk of a bitch. After having employed in vain a series of the measures used in like cases, this one resulted in a cure. The animal was a fine large hound of four years, which gave from eighty to one and ten *centilitres* of milk daily. About the middle of the second month a notable improvement became manifest in the condition of the bones and muscular movements. At the commencemant of the third month the child began to walk ; at the hundredth day its health was good, the curvatures having nearly disappeared, and the child walked without aid. The result is easily explained by the comparative analysis of the human milk and the milk of the dog. Thus, according to the analyses of M. Jaacqueme, the human milk contains only in 1,000 parts 26·66 of butter, 39·26 of casein and extractive matter, and 1.38 of salts ; while that of the dog has 97·20 parts per thousand of butter, 117 of casein, and 13·50 of salts.

SALICYLIC ACID.—Amongst disinfectants the newly-discove-ed acid. salicylic, bids fair to take a high, if not the highest, rank. It is a compound of carbolic and carbonic acids, taking the form of a pulverised crystal, which is readily soluble in hot water, alcohol, or ether. As an antiseptic it is found to be superior to carbolic acid, owing to its entire freedom from smell or taste. This latter quality renders it specially valuable in the preservation of food of all kinds. The properties of the acid have been tested in Germany, where the discovery of its composition was first made by Professers Kolbe, Neugebauer, Knop, and Thiersch, and experiments are still being prosecuted to still further test and develop the utility of this antiseptic. Professor Kolbe found from experiment that half a gramme of the acid would suffice to check the fermentatiou produced by five grammes of beer-yeast, acting on 120 grammes of sugar dissolved in the litre of water. From this experiment he suggests its utility in checking the second fermentation of wines, beers, liquors, and essences, as well as its value to prevent the growth of mould or fungi in casks. In the preservation of milk, it was found that the addition of 0·04 per cent. of salicylic acid delayed the process of curdling for thirty-six hours over that milk which had not been so treated. As a preservative of potable water, used on board ship, from putrefaction, either by the admixture of one part to 20,000, or by simply covering the buug-hole with cotton steeped in the acid, Professor Kolbe considers it to be peculiarly valuable. The highest value, however, of this acid arises from the fact that it can be applied to the human system, either internally or externally, without and injurious results. It has been used largely for dressing offensive wounds by Dr. Fehlong, in the lying-in hospital at Leipsic, and also by Professor Theirsch in his surgical practice. For application as a dentifrice, personal disinfectant or preservation from contagion, or for neutralising harmlessly the fetid odour of foul breath or by perspiration, the use of this acid will be invaluable.

TEST FOR LEAD IN WATER.—The following is a method of testing for lead in water described by MM. Mayengon and Bergeret. Plumbic sulphide is slightly soluble in soft water, and in water containing an excess of sulphydrie acid. If an excess of this gas be passed through a lead solution and then filtered, the clear filtrate will contain lead, as can be proved by passing a galvanic current through it, when the negative platinum electrode will be found covered with lead. It is converted into chloride, and tested by potassic iodide.

RECEIVED.—The London Medical Record, The Medical Press and Circular, The Students' Journal, The Sanitary Record. Communicatons from Mr. L. Stevenson and Dr. Pye-Smith.

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IN his lecture on Medicine, Dr. WILKS, speaking of Pleuritic Effusion, says, "No more important disease can attract your earnest attention than this, for the ability to ascertain the presence of fluid in the chest may enable you to save a fellow-creature's life, while ignorance of the diagnosis will let you stand by and see him die before your eyes." This fact must have been indelibly impressed on the minds of the Residents of this Hospital during the past week. On the 11th inst., a patient, *aged twenty-nine*, was admitted into Clinical Ward, giving a *history of three weeks' pain in the chest, with cough and slight expectoration.* He presented the usual negative signs and was thought, from the comparatively short history, absence of rigors and pyrexia to be suffering from serous, rather than purulent effusion, into his left pleura. The same evening he was seized with severe dyspnœa, and must have died in a few minutes but for the speedy introduction of a trochar and canula. Five and a half pints of purulent fluid were withdrawn, and instant relief afforded.

The second case was admitted into Philip Ward, on the 12th inst., *aged fifty-four. The history of cough and pain in the side was twelve weeks, i.e., four times as long as it was in the other case.* The fluid filled the chest to the third rib in front, and to the spine of the scapula behind, and the right lung was impeded from properly performing its functions by bronchial inflammation. The patient at first improved, but, on the second night, his distress rapidly became extreme; the face was blanched, extremities cold, and skin covered with cold moist sweat. By means of a trochar and canula three and a half pints of serous fluid were drawn off from the chest with immediate relief.

Having ascertained that a patient is suffering from pleuritic effusion, the next thing to find out is the character of the fluid effused; because, if it be serous, the fluid may become absorbed, whereas if we believe purulent matter to be present, the rule is to evacuate it; for it is useless to look for absorption, this occurring only very rarely. Of the former we might mention an instance familiar to many of our readers. A policeman on duty at Woolwich (on the day that the Shah visited the Arsenal) caught cold, and was soon afterwards admitted into this Hospital under the care of Dr. MOXON. The chest was very nearly full of fluid, but there was no distress of breathing. Dr. MOXON ordered diuretics, and only allowed half a pint of milk in twenty-four hours; the result was that the patient in a very short time emptied his own chest of what is not at all bad nutriment.

From the histories given, the second case would much more likely prove to be purulent than the first; his age, moreover, and asthenic condition would have been in favour of pus, if either had empyema, but both were thought to be serous in character. As to the means tried for the evacuation of the fluid, in these two cases urgency demanded immediate operation, so the trochar and canula were used; but had time allowed, and the aspirator been brought into service, the result could not have been more satisfactory. After seeing this instrument used on several occasions, we cannot but think

that, in by far the majority of cases, the trochar does the work effectively and is much more applicable as being always in working order, and much simpler in its appearance. Perhaps some air was admitted into the pleural cavity iu the case in Philip Ward, but if so it was but very little and the crackling in the cellular tissue of the back is certainly no more marked thau it was in a case in Clinical some time since, in which the aspirator worked most effectively.

NOTES ON HISTOLOGY.

(From DR. PYE-SMITH'S Demonstrations of Practical Physiology.)

(Continued from age 172.)

CELLS.—This term was originally applied to any small cavity, as the cells of a honey-comb, the "air-cells" of the lung, and those of "cellular" membrane, now called "areolar" or "connective" tissue, though the old name survives in the phrases "pelvic cellulitis" and "cellulo-membranous ulcer." Such mere spaces are now named areolæ, loculi, or vesicles.

The next definition of the term was applied by Schleiden in Botany, and by Schwann in Animal Histology (1839) to certain microscopic elements of plants and animals; those namely which possess a structureless closed cell-membrane, a solid kernel or nucleus, and fluid cell-contents. All, or nearly all of these minute vesicles are (or have been) cells in the modern sense of the word, but the term is now applied more widely.

A *cell*, then, as we at present define the word, is a minute mass of living protoplasm. Its size is microscopic; its shape spherical, but capable of indefinite change, either by its own movement, or by external pressure. The protoplasm* of which it is composed is characterised—

Physically, by its colloid, viscous, or jelly-like consistence, and by the absence of structure, being either transparent (hyaline) or faintly granular.

Chemically, by belonging to the protein-group, more or less closely allied to albumin.

Functionally, by its power of contraction, of nutrition, and of reproduction.

Most animal cells have part of their protoplasm differentiated to form a *nucleus*, characterised by its nearly uniform size, bright refraction, absence of power of movement, and reaction to acetic acid. Young cells which have not acquired a nucleus are known as "cythodes" (on the way to become a cell, a word coined by Milne-Edwards on the analogy of cathode and sarchode, but like the latter often spelt without the aspirate). They resemble the lowest living organisms —*Monera*.

Many cells are invested by a delicate membrane of structureless protoplasm, which is the true cell-wall (in vegetable cells the "primordial utricle" of Mohl). These are like the *Lepamœbœ*, while naked cells resemble *Gymnamœbœ*.

Many cells after acquiring a nucleus and cell-wall lose the power of contraction, and secrete (or separate) from the fluid (plasma, sap, or liquor sanguinis) in which they live certain chemical products. These are stored up in the cell in the form of watery solution of sugar, salts, &c, of oil-drops, of pigment molecules, of starch granules, &c.; and form the *cell-contents*, which are dead, manufactured products. As these increase, the protoplasm diminishes, and the nucleus is squeezed to one side. Other cells (especially those of plants) secrete a coat outside their original cell-wall, which is usually the more conspicuous of the two.

Thus a great many cells are found with no power of movement, with a nucleus, fluid cell-contents and a thick well-marked (secondary) cell-wall. This is the condition described by Schleiden and Schwann.

After moving, or secreting and reproducing, a cell degenerates, undergoes chemical change, dies, and is broken up.

VEGETABLE CELLS.—Yeast. Notice the size, shape, sharply-defined outline and nucleus. Asci from puffball. Basidia from mushroom. Spores and mycelium of Penicillium.

Large cells of potato, seen in section, surrounded by a thick cellulose (secondary) wall, and filled with starch granules. Smaller cells of carrot containing pigment. Cause of hexagonal and elongated shapes. Cellular tissue of cork. Epidermic cells of cuticle and hairs of nettle. Parenchymatous cells of the same, containing chlorophyl.

Vegetable fibres. The ribs of leaves, *e.g.*, nettle and tea (a frequent foreign body): spiral vessels: woody fibros: dotted tissues: so-called glandular fibres of deal (a foreign body). Rhaphides in rhubarb and onion.

ANIMAL CELLS.—*Leucocytes.* Embryonic cells, young cells, wandering cells. Forms of Leucocytes: Lymph-cells, splenic corpuscles, white blood-cells, pus-cells. Compare them as to size, opacity, nucleus. Colourless corpuscles of human blood, of frog and of newt. Watch amœboid movements: accelerate them by warmth. Send stream of salt solution through. Add dilute acetic acid. Stain with carmine.

Blood-discs. Their origin. In frog's blood observe their size, shape, outline and nucleus. Add water; dilute acetic acid; syrup. Watch their change of shape as they roll over during irrigation. Compare the red corpuscles of a drop of your own blood. Notice their shape, size, and the absence of nucleus: their occasional crenate or "thornapple" appearance; and the formation of rouleaux. Compare them with the blood-discs of a pigeon and a bullock. *Blood-crystals.* Hæmoglobin† (C, H, O, N, S, Fe). Its complex and unstable constitution. Crystals from human blood. Tetrahedra from guinea-pig's. Hæmin (C, H, O, N, Fe, Ce) crystals, artificially produced from dried-up blood, by mixing with common salt and warming with glacial acetic acid. Hæmatoidin crystals, probably identical with Bibirubin (C, H, O, N) in corpora lutea or old apoplectic clots.

* A word introduced by Max Schultze (late Professor of Anatomy in Bonn). It answers more or less to Milne Edwards' *Sarcode*, and Dr. Beale's *Bioplasm*.

† Otherwise known as Hæmatoglobulin, Hæmatocrystallin, and Cruorin. Though crystallisable it is not diffusable through animal membranes, and therefore belongs to the "colloids" not the "crystalloids" of Graham.

ROYAL COLLEGE OF SURGEONS.—J. Cooper Forster, Esq., F.R.C.S. Surgeon to and Lecturer on Surgery at this Hospital, has been elected on the Board of Examiners in the place of J. Hilton, Esq., one of our Consulting Surgeons, who has recently resigned.

Report of a Case.

DOUBLE COMPOUND FRACTURE OF LEG.—PYÆMIA.—TETANUS.—DEATH.

A boy, æt. 10, who was engaged in removing and sifting some dust, sustained a double compound fracture of both tibiæ and fibulæ by the heap falling upon him. He was knocked down and covered by the dust, then was brought to the Hospital, and on admission was thoroughly begrimed Besides a small cut on his chin, there was a large wound on each leg about the junction of the lower and middle third. That on the right was about three inches long and more jagged than that on the left, which was about five inches long. The upper fragments protruded. The right fracture was nearly transverse and slightly comminuted. The fracture of the left leg was more oblique, and the upper fragment was fissured. The hæmorrhage was not excessive, and the tibials were intact on each side. The wounds were full of dust, which adhered to the tissues very firmly.

He was placed under chloroform, and Mr. Colley proceeded to drill the bones, and then by passing silver wire through the holes, brought the fragments into position, and retained them there. The limbs were placed on back splints, side splints were adjusted, and the carbolic dressings employed. The wounds were well syringed out with carbolic lotion to clear them of the dust with which they were filled.

On the evening of the same day the temperature was 103. Pulse 120.

The next morning (15th) the temperature was 101·4, pulse 120, and in the evening, temperature 102·6, pulse 104.

On the 16th, when dressed, the wires were found loosened, and the lower fragments displaced slightly backwards in both limbs, the displacement being greatest on the right side. Temperature, both morning and evening, 102·4, pulse 140.

17th.—A small painful swelling was complained of over the left clavicle. In the evening the temperature had risen to 103, with a pulse of 142.

18th.—The wounds were suppurating, but there was no increased displacement of the bones, the surfaces of which were pink. The temperature sank to 102 in the morning, and 101·6 in the evening, and the pulse to 124.

19th.—A painful swelling appeared over the tenth rib on the left side, giving rise to painful breathing. There was no indication of any fracture. Increased temperature, it being 103 in the morning, and 102·2 in the evening.

20th.—Temperature, morning and evening, 102·4, pulse 138. Suppuration fairly established. Diarrhœa set in. He is very thirsty, and occasionally cries out, complaining of a pain in his abdomen. He lies with his eyes shut, and if asked a question does not answer till it has been repeated, then it is in a plaintiff, moaning voice.

21st.—Temp., morning, 102·6, pulse 140 ; evening, temp., 102, pulse 134. Bowels excessively relaxed, motions passed into the bed. ℞ Mist. Hæmatox, p. r. n.

22nd.—Temp., morning, 101·1, pulse 128 ; evening, temp., 101·5, pulse 144. Free suppuration in the wound. Fragments much displaced on the left side, and the splint was changed. The position was better on the right. The right knee-joint was swollen and red, not particularly painful. An opium enema was administered for the diarrhœa.

23rd.—Temp., morning, 100·5, pulse 126 ; evening, temp., 101·5, pulse 144. There is decided trismus. The drowsiness and diarrhœa contiuue.

24th.—Temp., morning, 99·4, pulse 122. The trismus was very marked. The left wound in the left leg looked unhealthy, and the right was painful and swollen. Mr. Howse therefore amputated the left leg about three inches above the condyles of the femur. The flaps were anterior and posterior. While under chloroform the splint on the right leg was changed, and the fragments re-adjusted, but they could not be very well placed, on account of the feeble vitality of the skin of the foot. There was no attempt at repair in either leg. Temp., evening, 100.

25th.—Temp., morning, 99·3, pulse 128 ; evening, temp. 100, pulse 136. The trismus continues, but no other tetanic symptoms have developed. ℞ Hyd. with Cret. gr. j., Pulv. Opii gr. ¼, quartis horis.

26th.—Temp., morning, 99·8, pulse 140. The stump was dressed, and there was no union of the flaps. Their inner surfaces were coated with dark clots. These were removed, the surfaces oiled and separated by a piece of oiled lint. The dressing was antiseptic. Opisthonos and pleurosthonos to the right side appeared. Spasms did not occur very frequently. Patient less drowsy, and spoke more freely.

27th.—Temp., morning, 103, pulse 156, irregular. Diarrhœa not so bad. No repair in stump or leg. Opisthotonos and pleurosthotonos are more marked. He is becoming more drowsy again.

28th.—Died at 4 a.m. He had considerable difficulty of breathing in the night, and seemed in great pain.

Autopsy.—No attempt at repair was noticed either in the stump or wound in the leg. Pus was found in the knee-joint over the left clavicle, and over the tenth rib on the right side, the bone being bare in the last two situations. The left lung was affected with broncho-pneumonia. The brain weighed 52 oz.

One special point of interest about this case was the concurrence of pyæmia and tetanus, tending to support the theory that the latter as well as the former is due to blood-poisoning.

Physical Society.—The last meeting of the Session will be held this evening at 7.30 p.m. The proceedings will be specially interesting on account of the presence of Mr. Cock in the Chair. The names of the successful competitors for the prizes will be announced.

Appointments.—Mr. Shirley F. Murphy, M.R.C.S., M.S.A., a late House Surgeon of this Hospital, has been appointed Resident Medical Officer to the London Fever Hospital, Islington, vice Dr. F. Mahomed appointed Pathologist to St. Mary's Hospital.

Doctor's Carriages.—A venerable physician of Philadelphia, still living, Dr. Condie, the author of a book on "Diseases of Children," would never keep a carriage, notwithstanding his large practice, and is made responsible for this *mot*, 'If a doctor drive one horse, it indicates physical weakness : if he drive two, mental weakness.'

MARCH 3rd, 1875.

DEDICATED TO THE VICTORIOUS TEAM.

"Along with them,
They brought one Pinch(ing)."—Comedy of Errors.

Niger, a "reading man," encounters Albidus, an "athletic man," and the following dialogue takes place:—

Niger. Ha! Albidus, you always know whatever's going on;
What is it stirs the 'Spital,* from the Treasurer down to Mon?
Tell me what mean these earnest groups that throng the Colonnade,
And talk of "George's" and "the Cup," and how the odds were laid.

The "Rooms" are filled with gentlemen who drink the health of Mutch,
Or rave about a "clever goal," and "running into touch;"
Oh! why this general hubbub? Why this universal glee?
Explain, my Albidus, explain this mystery to me.

Albidus. What, Niger! is it possible? or hast thou yet to learn
The victory that our pluck and skill have just availed to earn?
But let us turn aside while I endeavour to make clear,
What fills us all with triumph, and induces such good cheer.

'Tis of the Challenge Cup you hear, and of the final tie,
From every man of every year, who loves the name of Guy;
For Bart.'s and King's, and all the rest in detail overthrown,
St. George's and ourselves were left to fight it out alone.

There, on the turf, I spotted more than one familiar face,
That every Guyite knows, who's been a week about the place;
The staff was represented, too; honour to those who came,
Their presence cheered our champions on, and helped to win the game.

Thus, passing on from group to group, we strolled about the ground,
With here a laugh, and there some chaff; good humour reign'd around;
But shortly after three o'clock, a murmur, then a shout
Proclaimed to an excited crowd, "The teams are coming out!"

And forth they stepped—a gallant band—defiant, proud of mien—
Guy's in the oft victorious stripes, St. George's sporting green;
I think I ought to mention, as my narrative is true,
We noticed every hero's nose and knees were rather blue.

First strides the gallant "Nipper"; mark the vigour of his "phiz,"
The scars upon his nose denote "the sort of man he is";
Walks at his side, his right hand man; broad shouldered and erect,
Osborn to wit. Who Osborn is, I leave you to detect.

Then come the backs, three nimble backs, Pearson and Finch, and Gray;
Right well they know, on them will fall some heavy work to-day;
Keen are their eyes, their muscles strong, and firmly clenched their teeth;
'Tis plain they mean to carry back fresh laurels to Blackheath.

Who is the somewhat lengthy man, who makes the Georgites laugh,
And whisper rudely *apropos* of "Anak," and "Giraffe"?
Little he heeds their prattle, but before the day is done,
I fancy Duke will be avenged for all their feeble fun.

The other members of the team, I won't do more than name;
Are they not writ in largest type on the broad page of Fame?
Breach, Wallis, Kendall, Mutch, Maclean, Hetley, and Gilbert, Keer,
And Welchman, last but not least; what can we have to fear?

The Georgite champions, one and all, are on the spot and well,
Though of their individual form I have'nt much to tell;
Collins and Jennings, towers of strength, make every Guyite feel,
In them at least our men have met foes worthy of their steel.

The men are placed.—We've lost the toss, and have the wind to fight,—
Gray starts the ball. By Jove "Well kicked!" t'was like an arrow's flight.
How the wind stops it! Hang the wind! One of the George's backs
Has got it, and towards our goal is making speedy tracks.

Collar'd! Hurrah! and down he goes, a scrimmage soon begins,
That's not without a spice of risk to the performers' shins;
This way—that way—St. George's—Guy's! the battle ebbs and flows,
While Mutch emerges from the fray with blood upon his nose.

At last it's out—Breach tries a run—ten, twenty yards or more,
Then stumbles, and we're treated to the scrimmage as before;
While the perspiring players pant, 'tis ours to rend the skies
With shouts of "Take it thro'," "Wire in," "Shove George's," "Well shoved Guy's."

The ground's becoming "greasy," and its' getting near half-time;
Above the din, from yonder church we hear the quarter chime:
At length a kick, a sudden rush down to the western end,
And Guy's, alas! must yield a "touch" their quarters to defend.

First blood to George's; how they shout and offer two to one
Have patience my excited friends! wait till the game is done:
But fate is still against us, and they score a second "touch,"
Producing obsecrations from myself and friends — in Dutch.

The gods be praised, half-time is called, now for a change of ends!
Which means that we've the wind with us. "Play up, play up, my friends!
As watching's rather chilly work I now a weed ignite;
Excitement getting furious as the end of it I light.

The players suck a lemon each and then renew the fray,
But inch by inch and foot by foot, the ball is forced our way;
'Twill be another touch for them we one and all allow,
O! Spirit of our founder, Guy, pray for thy children now.

Ah, no! deliverance is at hand, for one divinely tall
Darts from the thickest of the fight, triumphant with the ball;
Away! away! pursued in vain, down to the other end,
Pearson! upon thy trusty foot our very lives depend.

A "brilliant run" o'er half the ground, and then a "clever drop,"
Were every foe a Collins, such a run they could'nt stop;
The fortunes of the day are changed, and ours are now the cries
That soon proclaim thro' Kennington, "a touch, a touch for Guy's."

Yet fate has better still in store, when from the struggling hosts
The crafty Mutch with ball in hand, starts for St. George's posts;
Wildly they seek to bar his path, vainly they hem him round;
There in the centre of their goal he brings the ball to ground.

Now for the "try at goal"—in truth it is a ticklish thing;
Mark how the foemen stand in line, and ready for a spring;
Their line however's useless, and they don't spring very far,
When Gray serenely sends the ball careering o'er the bar.

One lusty shout of triumph, and again we watch the play,
Ten minutes yet 'ere time is up—time yet to lose the day,

* 'Spital, an old term, rarely used, and only introduced here in deference to the requirements of the metre.

Play up, St. George's, play up Guy's, the battle waxes fierce,
Bravely again, but all in vain, they strive our ranks to pierce.

So time was called—the cup was ours—and shall I e'er forget
The cries of victory we raised? my ears are ringing yet;
Bravely we fovght, and fairly won; nobly St. George's played;
I went at once and drank their health in foaming lemonade.*

I fancy though it was'nt good, that lemonade I drank,
For all that happened afterwards appears a perfect blank,
Or possibly it may have been those two-penny cheroots;
At any rate I know I woke this morning in my boots.

Niger! my simple narrative is at an end, and now
You know why looks of triumph sit on every Guyite brow;
The next thing is to win the shield, to place beside the cup,
God save the "Nipper" and his men—we'll never give it up.

* We have reason to doubt the accuracy of this statement, and believe that it had its origin in the exigencies of rhyme.—Ed.

The Surgery.

Amongst the out-patients relieved in the Surgery we have had a much less number of interesting cases than we reported in last week's *Gazette*. There have been two cases of separation of epiphysis; in one case, the lower epiphysis of the humerus was separated from the shaft of the bone, in the other, the lower epiphysis of the radius was separated from its attachment to the shaft of bone.

The first of these occurred in a child aged 7 years, the forearm with the articular surface of the humerus was displaced backwards, the displacement being easily remedied by extension, but again occurring when traction on the arm was discontinued; the limb was put up on a right angled splint applied to the anterior surface of the arm and forearm.

In the other case the patient was a boy aged 17; the accident resulted from a fall upon the extended palm. There was no very marked deformity nor was the lower and of the bone completely severed from the shaft, there was also an absence of distinct crepitus, and the whole bone moved on pronation and supination of the hand, but there was great pain on movement and on pressure over the lower end of the radius; about half an inch above its articular surface on the posterior aspect of the forearm there was a prominent ridge running transversely across the radius and beyond this was a depression; from these signs and from the nature of the injury we diagnosed separation of the lower epiphysis of the radius and impaction of the lower end of the shaft. The arm was put up with anterior and posterior splints, but it was found impossible wholly to reduce the displacement of the epiphysis.

In addition to the above there has been one case of Colles' fracture in an old woman aged 82, caused by a fall upon the extended hand; and a case of fracture of the olecranon process in a man aged 35, the result of direct violence. In the former case the displacement of the bones could not be remedied. and the arm was put up in the same way as in the case given above. In the other case where there was no very marked drawing up of the olecranon, the arm was put up almost fully extended in a firm leather splint.

Two severe cases of diffuse inflammation of the cellular tissue of the palm of the hand have also been treated. In the first case the patient was a man aged 45, who had some suppuration beginning about a corn situated in the palm of the right hand. From this source the inflammation extended through the palmar fascia into the sheaths of the tendons and there started suppuration. In the other case the inflammatory action was started by a wound in the palm by a stab with a fork. In both the symptoms were the same, namely, great pain with constitutional disturbance, œdema of the back of the hand, and swelling and tension of the palm, extending up beyond the annular ligament. In both also the treatment was the same, namely, an incision into the palm, through the palmar fascia, the opening into the deeper parts being enlarged with the dressing forceps by Mr. Hilton's method; the constitutional disturbance being met by the administration of a free purge, followed by ½dr. doses of tinc. ferri perchlor, with opium and mist. cinchoninæ.

The progress of the two cases of compound dislocation of the thumb, reported in last week's *Gazette*, has been unsatisfactory. In the case of the old man, inflammation and suppuration extended along the muscles of the thumb, free incisions were made both in the palm and on the dorsum of the hand. The suppuration did not extend beyond the outer side of the hand, and the patient is now going on fairly well. This case was dressed antiseptically, and compares favourably with the other in which, after reduction of the dislocation, the wound was dressed with the compound tincture of Benzoin; in this case suppuration has extended along the muscles of the thumb into the palm, and beneath the annular ligament amongst the tendons of the flexors of the fingers; the thumb itself has become gangrenous. This patient is now in Astley Cooper ward, under Mr. Durham's care: like the cases above he has been treated with free incisions and tonic medicines.

Operations.

Friday, March 12.

Mr. Durham performed perinæal section on a man who had been admitted into Naaman Ward two days previously for stricture. The operation had been performed once before some time ago, and the perinæal opening had never been fully closed. The patient is doing remarkably well.

Mr. Durham performed perinæal section on a boy for rupture of the urethra. Since the injury the boy had passed water freely several times, but extravasation was beginning to take place. Mr. Durham said that, under the circumstances (there being no doubt of the correctness of the diagnosis), abscesses would invariably follow, and that it was best to perform perinæal section at once, while the tissues were still in a healthy state. A sound was passed to the seat of the rupture and was cut down upon.

The posterior portion of the urethra was successfully reached, and a catheter tied in. Last Thursday a catheter was passed along the whole length of the urethra and tied in.

Mr. Durham also opened an abscess in the abdominal walls, about an inch above the pubes. Palpation over the tumour gave rise to a gurgling sound, and a sensation resembling air moving in fluid. The diagnosis was, however, determined in favour of abscess by the thickening around the tumour, the absence of any intestinal trouble, and the inflammatory blush on the surface. Very offensive pus and air were found in the sac.

Saturday, March 13.

In the evening Mr. Durham operated upon a femoral hernia, which had been strangulated for twenty-eight hours. The case was an interesting one, and will perhaps be reported more fully in another issue. The sac was opened, and two pieces of omentum ligatured with catgut and cut off. The patient is suffering from peritonitis, but good hopes are entertained of her ultimate recovery.

Wednesday, March 17.

Mr. Durham gave a clinical lecture, and operated on three cases. The first was a fatty tumour as large as a cocoa-nut, and was situated at the back of the neck. It had been growing for twenty years. The growth was removed by horizontal elliptical incisions, a portion of skin being cut away. The tumour was highly vascular.

The second was a tumour in the axilla, which seemed, from the history, to be primary malignant disease of the axillary glands. In the course of the operation the axillary artery and vein, with many large branches, were exposed. The tumour extended for some distance upwards, and its removal took a considerable time. A considerable quantity of pus was let out in the course of its removal, and there seems some doubt as to the real nature of the tumour.

The third case was one of epithelioma of the ear. The growth was removed, and this involved the loss of almost the whole of the external ear. There is an enlarged gland in the neck, and Mr. Durham pointed out that it will be necessary to watch whether it subsides or not. Should it disappear, it will of course have been caused by the mere irritation of the adjacent sore, but if it should increase it will show that its enlargement is due to infiltration of cancerous matter, in which case it will have to be excised.

Mr. Bryant operated for removal of an ovarian cyst. The abdomnial cavity being opened, about a pint of a yellow glairy fluid escaped, which led Mr. Bryant to suspect that a cyst had ruptured into the pertonæal cavity. The main body of the cyst was then tapped, and there being no adhesions the tumour was easily extracted. Its more solid part was found to be at the point furthest from the pedicle, and a small cyst in this portion was found communicating with the pelvic cavity by a rounded opening. The clamp was applied and the pedicle cut through as usual, and some fluid was removed from the pelvic cavity by means of sponges. The abdominal wound was secured by silken sutures. The patient is doing well.

Correspondence.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

To the Editor.

Sir,—In the interesting account of dislocations lately treated in the Surgery, given in your last number, the subject of diagnosis of sub-glenoid dislocation of the humerus was raised. I doubt, however, if any or all of the signs enumerated are sufficient to establish the differential diagnosis between this somewhat rare form of dislocation and the ordinary sub-coracoid dislocation. The amount of abduction of the elbow is doubtless important, and so in a less degree are the increase in the depth of the anterior axillary boundary and in the vertical circumference of the shoulder and the pressure of the head in the axilla—as felt by the fingers placed there. But all these signs are present in both forms, though more marked in the sub-glenoid variety. The point which I think is most characteristic is *lengthening of the arm* as measured from the prominent angle at the junction of the crest of the spine of the scapula with the acromion process to the tip of the external condyle of the humerus. This lengthening is, I think, necessarily present in the sub-glenoid dislocation when the elbow is pressed near to the side, and amounts to an inch or an inch and a quarter. In the sub-coracoid dislocation there may also be *slight* lengthening, but more frequently, I think, there is either slight shortening or no perceptible alteration in length.

A more difficult, but perhaps still more certain test, is the possibility in the sub-glenoid dislocation of pushing a finger from in front between the coracoid process above and the head of the humerus below.

I am, &c.,

An old H. S.

March 17th, 1875.

FOOTBALL.

Last Saturday the Guy's first fifteen played their final match for the present season against the Blackheath Club, on the ground of the latter, in the presence of a great number of spectators. The Guy's team was a fairly good one, although not by any means as good as the one which carried off the champion cup against St. George's. Blackheath played for the most part their usual team, but were deprived of the excellent services of L. Stokes. A. W. Pearson, Gray, and Finch, who sometimes play for the Blackheath Club, on this occasion played for Guy's, as indeed they were in duty bound to do.

Pinching having lost the toss as usual, the ball was started by Gray at 3.30 against a strong wind. For the first ten minutes the game was carried on very near to the Blackheath goal line, and once or twice it looked as if Guy's would score, but the aspect of affairs soon changed, for by the aid of some good drops from Poland and J. G. Pearson, assisted by the wind, the ball was rapidly taken down to the other end of the ground, and forced over the Guy's line,

where A. W. Pearson had to touch it down. The ball was dropped out by Gray, but, notwithstanding some good runs by Maclean, it was soon driven back again, and Pearson had to touch it down a second time. The ball having been dropped out by Gray, the game was once more renewed in the Guy's quarters, and in a few minutes Rawson managed to get by Breach and touched the ball down. The try which was not a very easy one proved successful, and Blackheath scored a goal. From this up to half-time the game was carried on near to the Blackheath goal, A. W. Pearson making one or two good drops in the very teeth of the wind. After ends had been changed it was hoped that Guy's, with the wind in their favour, might retrieve their losses. The ball was started by J. G. Pearson and returned by his brother with one of his long drops, and now the Guy's forwards began to play up very hard. It was noticeable all through the match that the Guy's forwards had much the best of it in the tight scrimmages; they went in in splendid order, with their heads down and aided by their superior weight invariably pushed their opponents over, once or twice running them along a considerable distance, but as soon as ever the scrimmage broke up and became loose, the Blackheath forwards more than made up for the ground they had lost in the tight scrimmages. About this time, the ball having been carried down to the front of the Blackheath goal, Gray took his drop, but unfortunately just missed and the ball was touched down by Blackheath. Soon after this the ball was again worked down by the Blackheath men, and J. G. Pearson made his mark very near to the Guy's goal, but the try was unsuccessful and only a touchdown resulted. The Guy's forwards now once more played up vigorously, and soon carried the ball to the other end again, Maclean's drops at this time being unusually good, and when the ball was just in front of the Blackheath goal the latter made a splendid drop at goal, but this, like the former one by Gray, was unsuccessful, and only a touchdown resulted. After this until no-side was called nothing occurred except that Gray made a splendid run and drop, from which nothing resulted; so the game, which was very even throughout, was won by Blackheath by a goal, a try from a fair catch, and three touchdowns to two touchdowns, both of which, it must be remembered, were scored after very near drops at goal. The play of A. W. Pearson for Guy's, and his brother for Blackheath, was remarkably fine. Maclean played better than we have seen him before for some time, his drops with the wind being very effective. Gray was perhaps hardly up to his usual form, but he dropped well at times.

All our forwards played well in the tight scrimmages, and all played badly in the loose; they would do well to practice dribbling a little more before next year.

For Blackheath, Rawson was as usual very good.

The following composed the Guy's team:—Forwards—Pinching (captain), Osborn, Hetley, Keer, H. Duke, Gilbert, Welchman, Gibb, Wilkinson, and Roberts; half-backs—Finch and Maclean; three-quarter back—Gray; backs—A. W. Pearson and Breach

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Messrs. J. W. Bull and D. T. Evans have been appointed Clinical Assistants for the summer months.

We are unable to insert one of Dr. Hicks' lectures this week, but hope to continue them in our next issue.

The Wards.

The following Cases were admitted between March 11 and March 16

MEDICAL.

ADDISON—4—Acute rheumatism. 5—Bronchitis. 8—Acute rheumatism. 22—Chorea. 23—Diabetes. 38—Debility.

BRIGHT — 8—Acute rheumatism — Pericarditis. 12—Apoplectic attack.

PHILIP—5—Bronchitis. 9—Cirrhosis—Ascites—Death. 9—Morbus cordis. 13—Phthisis. 19—Hæmatemesis. 22—Acute rheumatism. 24—Acute rheumatism. 27—Desquamative Nephritis—Morbus cordis. 29—Locomotor ataxy. 32—Podagra. 39—Phthisis. 43—Chorea—Morbus cordis. 47—Pleuritic effusion (Paracentesis). 49—Abdominal aneurisim ?

MARY—5—Neuromimesis. 13—Fits. 14—Hæmoptysis. 36—Tortuous constricted cervix. 38—Ovarian disease.

MIRIAM—1—Broncho-pneumonia. 2—Congenital syphilis. 3—Emaciation. Cots—26—Dyphtheria. 27—Morbus cordis. 29—Chorea. 30—Gastric ulcers.

JOHN—5—Morbus cordis. 6—Phthisis. 14—Acute rheumatism.

STEPHEN—11—Cirrhosis of Liver—Ascites 19—Neuromimesis. 22—Spinal curvature. 26—Gastritis. 29—Right Hemiplegia—Aphasia. 47—Gout.

SURGICAL.

Mr. J. J. Newman, Dresser for the week.

ACCIDENT—13—Cut throat and injury to wrist. 17—Fracture of fibula and inner Malleolus. Injury to face and arm from explosion.

LYDIA—16—Morbus coxæ.

DORCAS—3—Hernia, femoral 6—Epulis. 9—Scalp wound. 11—Pott's fracture. 16—Lipoma. 18—Scirrhus of breast and enchondroma of finger. 22—Axillary tumour. 24—Swallowing boiling water. 25—Run over arm. 26—Fractured thigh. 27—Scald from parafin—Death.

LUKE—4—Abscess. 8—Hip joint disease. 15—Calculus vesicæ.

NAAMAN—4—Fractured thigh. 9—Stricture. 11—Stricture. 21—Ulcers of leg. 22—Disease of knee.

MARTHA—1—Disease of knee-joint. 4—Tumour of breast. 6—Tumour between ribs. 7—Burn. 9—Disease of knee-joint. 10—Whitlow, amputation of finger. 11—Disease of knee-joint. 18—Adenoma.

CORNELIUS—2—Fracture of internal Malleolus. 4—Fractured femur. 7—Fractured clavicle. 8—Fractured tibia and fibula. 11—Scalp wound, injury to knee and back. 18—Compound-fracture of thumb—Gangrene. 19—Fractured fibula. 19—Necrosis of tibia. 20—Synovitis.

LARAZUS—4—Fistula. 10—Morbus coxæ (?). 14—Necrosis of elbow-joint—Orbital abscess—Syphilis. 15—Hydrocele.

JOB—7—Spinal disease. 8—Epithelioma. 18—Incised wound of knee.

RECEIVED.—The London Medical Record, The Sanitary Record. Communications from Dr. Wilks, Dr. Stevenson, Messrs. W. H. A. Jacobson and R. J. Pye-Smith, and "Old Guy's Man."

ANSWERS TO CORRESPONDENTS.—"Old Guy's Man"—We shall be happy to insert your communication on receipt of name and address.

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THE recent election of Mr. J. COOPER FORSTER to the Board of Examiners of the Royal College of Surgeons, and the fast approach of the April examinations suggest to us that a few remarks to intending candidates would not be inappropriate. Having, in one way or another, spent a good deal of time at the College during examinations, inferences from what one has seen and heard there, will afford ample foundations for the following remarks without drawing on suppositions and theory:—In the first place, let no one think that it is necessary to get into a great state of excitement in order to realise the importance of an examination, and to sit up until incredibly late hours and get up in the morning before the sitting-room and coffee are ready, during the last few days, in order to persuade himself that he has been doing his *utmost*. These things have been done, and done *frequently*, and generally with a bad result, or we should not mention them. The examinations are not competitive, so that if every man answered well, every man would pass. It is not necessary to know all the corners and catch questions of Anatomy, but it is necessary to know the ordinary plain facts one hears in the Dissecting-room, and to be able to recognise a structure in a dissection. It is true that sometimes there are atrocious questions asked in the *viva voce*, but these are riddles and there is all the more fun when they cannot be guessed. With regard to the "pickles," there is a most mistaken opinion prevalent, and one which it is a pleasure to correct. They are dreaded and that most unreasonably. It may fairly be said that there are, amongst the specimens upon which Students are examined, some of the most beautiful dissections we have ever seen. In these the arteries and veins are injected, and bits of coloured glass placed under each, so that if the candidate have any knowledge of Anatomy a mistake is impossible. There are some preparations certainly which look the worse for wear, and are rather ragged in parts, but even these are as good as the dissections generally found in a Dissecting-room. Of the fresh dissections there is little to be said, the muscles are generally red and the nerves white, and in this respect look like any other, but in *these* the arteries are uninjected and so may at first give rise to a little confusion but not a mistake. Suppose, for example, the brachial artery and its branches were injected blue, what *could* they be mistaken for? If the vena azygos were red, would anyone mistake it for the aorta? If the thoracic duct were filled with blue, is there any vein which runs in anything like the same course? But these things are not so. Men who have passed, conjure up ghosts to frighten those who have not: these have an air of reality, but lack the backbone of truth. We remember hearing once, when preparing for our First College, that the Examiners frequently made mistakes and rejected men for errors which had never been committed. This was a startling fact to every body, and each one felt that there was a stumbling block which no foresight could avoid; men went away sad and said, "What is the use of learning everything so carefully and correctly? Let us trust to chance." We do not accuse men of telling falsehoods in these matters for there

may be isolated instances to support every statement, but we do affirm that all those things which puzzle a man, and everything which tends to confuse him is eliminated from the examination room, and we have no hesitation in saying that if a man can answer well and readily in his own Dissecting-room, he stands very little chance of getting "plucked." The great thing is to keep cool and collected if one can keep so at such a time. Think rather of the things remembered than of those which are almost forgotten. An old demonstrator of this Hospital said, "In the paper, bear in mind, that the College does not expect a thesis on the subject or an elaborate *essay*, but simply a fair knowledge of the facts." The words are as true now as then. It is well to remember, especially when writing a paper, that a blunder is infinitely worse than a deficiency, therefore make no guesses, no "shots," put down only what is known to be right. A man is a better surgeon who stops short when his knowledge fails him than one who flounders on, ignorant of the consequences of his rashness.

A STUDENT'S NOTES OF

Lectures on Midwifery.

By J. Braxton Hicks, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

Lecture XIX.

Rupture of the Vagina.—I have already told you some of the modes by which this canal is ruptured, viz., from an extension from the margin of the os uteri downwards and upwards, and in the transverse direction somewhere near the junction with the uterus posteriorly from the pressure of the child's head on that wall natural to labour. Generally the lesion in this latter position opens up the peritonæal cavity, and thus hernia of the intestines may take place. I have heard of cases where, probably being mistaken for the funis, the intestines have been drawn down, and, extraordinary to speak, have been cut away. What can induce this latter act I cannot surmise. The practitioner's mind must have lost its balance. If it were the practice to cut away the funis in leugths, one might explain it, but when the child has been removed there is no cutting to be done. Still it has been done in five cases to my knowledge. Let this be a warning to you.

A curious case of ruptured vagina was told to me where the child, having escaped from the uterus, passed through a rent in the vaginal wall, into the peritonæal cavity along the iliac fossa, and thus the child perished in the abdomen. Sometimes there is enormous effusion of blood, which may prove instantly fatal. I have seen two cases of this kind. In one I could pass my hand through the rent into the cellular tissue posterior to the peritonæum, up as far as the kidney—an enormous extravasation of blood had separated the membrane, and my hand passed merely into this large thrombus; the rent was lower down in the vagina than the recto-vaginal pouch of peritonæum. The symptoms, of course, vary much with the extent of the rent and its position. Below the line of peritonænm the effect is less than above that point. Generally speaking, when above, there is collapse with cessation of pains, with hæmorrhage from the vulva: much the same symptoms as those seen in rupture of the uterus. There is, of course, no recession of the presenting part; but the rent can generally be discovered by examination. The abstraction of the child by forceps if possible, if not so by perforation, &c., is the treatment indicated. The operation should be done with the least possible disturbance.

There is another kind of rupture of uterus, where the canal is not sufficiently large or elastic for the head to pass, and it is stretched beyond its powers. In this case the lesion generally takes place at the median line before and behind. This I have seen not infrequently: occurring behind it, sometimes breaks into the rectum, or if before may open the bladder, causing vesico-vaginal, or recto-vaginal fistulæ. Once it occurred to me in employing the forceps; the vagina was rigid, and although there was not much obstacle, yet on seeing the blood flow from the anus, I examined and found a gaping opening above the sphincter ani. It soon closed up, and gave no trouble that I could hear of. Dr. Ramsbotham had a case which occurred twice in the same person. This kind takes place in the lower part of the vagina. With regard to treatment, practically it generally happens that the accident has occurred before we are aware of it; but to prevent its recurrence, rather than sacrifice the woman's comfort, and the child's life, the induction of premature labour will be the best plan.

Rigid Perinæum.—Tedious beyond degree is the rigid perinæum, and this tediousness is increased by the feebleness of the pains which so frequently accompany it. No doubt but that a good deal of the rigidity is due to spasmodic action, but a major part to mechanical firmness. Some dilating power must be employed, and as long as the pains are strong, so far natural efforts may succeed, but when they fail assistance must be given by vectis or forceps. If these are employed too early, before some distension by the child's head has taken place, and before the child's head is moulded the perinæum may tear instead of stretching. If we wait too long, the uterus, finding a resistance too severe, becomes irritable, continuous action gradually supervenes, and the first signs of exhaustive labour appear; and these effects commence earlier here than when the head is detained inside the uterus or higher up the pelvic cavity, so that we must be more on the look-out for these troubles.

But we must first in all cases relax the spasmodic element, without stopping, if possible, the pains. Small doses of opium, warm fomentations externally, enemata and warm vaginal injections should be employed, or chloroform inhaled to slight torpor; we generally find by using these that a surprising amount of the obstacle has passed away, and in some cases, if the pains are good, sufficient has been done to allow the head to escape. Should however the pains be still futile, we may carefully apply the vectis or forceps and abstract the head very slowly assisting each pain. When the head is escaping, it is best to draw it out during an interval, as then the perinæum is least rigid, for

there is doubtless a participation of the vagina and vulva in the general contraction of a "pain."

We cannot be too cautious, and hardly too slow, at this point; the hand not pressing on the perinæum, but bringing it forward, so as to ease the tension on the margin; the finger, if it possibly can be spared, pressing the head forwards while the handles of the forceps should be between the patients' legs close to the abdomen; yet even here care must be taken, for if this is done too abruptly the tips of the blades leaving the head a little may pass against the inside of perinæum, and hasten a rent. The head making a rotation in coming down, the posterior blade of the forceps is liable to make its edge prominent.

But should a rent be apparently unavoidable notwithstanding all our care, what can we do? Some have advised that we should make an incision from the edge on either side, say about three-quarters of an inch on either side the raphe for about half an inch. This prevents the rent passing through the sphincter ani, a point of much importance to which I shall again allude shortly.

The vectis is not a suitable instrument for this condition, because placed as it is posteriorly to the child's head, it comes out more or less in the centre of the perinæum adding thereby to the tension. In respect to the posterior blade of the forceps, should it by the rotation assume nearly this position, it has been recommended to draw both blades out and re-insert them in the transverse diameter of the outlet. The shanks of the forceps if wide apart, stretch out the perinæum, and tend to cause its rupture. This has been attempted to be obviated by the curving in this part, so that they are brought locked almost when close. Again if the blades are very curved, and the tips close together, unless they grasp the head well, in other words are well put on, they assume a greater width than the head and tend also to lacerate the perinæum. I have hitherto spoken of the rigid perinæum with head presentation. With breach much trouble arises, especially if we have to pass up our hand to hook down the thigh, we may very then readily rupture the perinæum. So in the aftercoming head, with its mento-occipital diameter engaged in the outlet, the rupture of the rigid perinæum is a thing which requires much care to avoid, especially since the birth of the head is imperatively demanded, or at any rate the stretching of the perinæum open sufficient to admit air into the mouth.

Physical Society.

The last Meeting of this Society for the present Session was held on Saturday, March 20th. Mr. Cock, Honorary President, in the chair. Dr. Pye-Smith, Professor Rienold and Mr. F. Durham were among the visitors. The minutes of the last meeting having been confirmed, the Chairman called upon Mr. Carrington to read his paper on "The Physiological action of Alcohol," of which the following is an abstract:—

The properties of Alcoholic liquids depend mainly upon their chief constituent, and they differ only in degree.

The action of Alcohol upon the organism when gradually pushed to the extreme is that of a powerfully depressing agent to the nervous system, although there is at first some excitement due to exhaustion of nerve force before its time.

Two distinct views are taken as to the action of the organism upon Alcohol. The facts of the case are, that in the analysis of the excretions after ingestion of Alcohol, the unaltered substance is found for thirty-six hours, and it is also discoverable in the tissues after this time, but the whole amount ingested has never been recovered. It is said on the one hand that there is, therefore, proof presumptive, that no change is undergone; but considering the delicacy of test employed, that those who take this view always used intoxicating doses in their experiments, and the observations of Dr. Anstie, who was only able to regain a very small amount, both in health and when enormous quantities were taken in prostration from acute disease, and finally the ready oxidizability of Alcohol, the conclusion is forced that some must be decomposed, and the limit would appear to be one-and-half fluid ounces of absolute Alcohol per diem.

Its potential energy probably appears as heat, although from its thermal effect being less than other calorificient substances, notably sugar, with an equal power of absorbing oxygen it has less effect in this direction. This is confirmed by the universal tendency of Alcohol, if it exerts any effect at all to lower the temperature of the body, but taken in dietetic doses it probably has no effect.

On the excretion of Carbonic Acid in large doses it undoubtedly has a lowering effect in small, probably none; but acts as a disturbing agent to the respiratory functions On the elimination of urea, there is no doubt that large doses have the same effect as in the case of Carbonic Acid, but amounts within the quantity capable of destruction by the organism do not influence this excretion.

It has no power of adding force directly from itself to the nervous or muscular systems, for its action upon them is one of paralysis. It is true that it adds to the force and frequency of the heart, but although this is partially explicable by the vascular delatation, due to paralysis of the vaso-mortar system; yet as there must be a limit to this action, and also because the effect upon the heart can be renewed. When it begins to flag, and kept up for some time by successive small doses, the action is only stimulant causing a premature exhaustion of the heart's force, and confirmation of this is afforded by the depression upon the excessive action.

As Alcohol is discharged in the system, and must yield up its potential energy; it must be placed in the same category as sugar, and other calorificient substance differing from them, however, in not being nitrogenetic.

The experience of the Red River expedition, of its use in cold and hot climates, the fact of teetotalism and much further evidence, show that Alcohol is not essential, and there is no doubt that in health it is not required, but it appears that within the limit of its power of destruction in the system it has no bad effect, always with the proviso that it be taken immediately before or after food; whilst in low states of the body, when digestion is impared in the case of bad food its action is beneficial, and in the adynamia of exhausting disease or in the case of shock, it is able to maintain the organism for a considerable time, to enable the patient to "turn the corner," and if used in the former cases it will facilitate and expedite recovery; which without it is long and lingering.

Mr. KIDD, in opening the discussion, said it was an important fact that the temperature was reduced by alcohol. He agreed with Mr. Carrington, in his remarks on alcohol as a food. Dr. Anstie and Dr. Pavy both considered it a food. But it did not seem clear how a substance which diminished the amount of carbonic acid and the amount of urea, which did not form fat, and in fact did not produce "force" could act as food. The urine was the largest channel of excretion when alcohol was taken in considerable quantities. The diminution of temperature might be partly due to the fact that tissue destruction was lessened, and therefore oxidation diminished. It had not been shown that the carbonates were increased to any large extent in the urine. The effect of alcohol was to produce congestion of all the organs of the body as seen post-mortem, and also atrophy of the brain.

Mr. SYMONDS said they knew that for the healthy life of the tissue there must be a certain amount of waste and a certain amount of repair, and if either were in excess healthy action would be interfered with. Sleep was the time when repair took place, and during sleep less carbonic acid was eliminated, therefore less tissue change was going on, and if alcohol produced a sleepy condition it must interfere with the vital action of the tissue, although it might be said to act as a food by lessening tissue waste it only did so by interfering with vital processes. In fever, the balance between repair and waste was disturbed if alcohol were then administered; it lowered the temperature

diminished the amount of carbonic acid exhaled, and so tended to bring up the balance in favour of repair, in that way acting indirectly as a food.

Mr. SHADWELL called to their minds Dr. Wilks' remark, that of all substances alcohol was the most used and yet we knew the least about it. Alcohol, when introduced into the system, seemed to have some effect upon the red corpuscles of the blood, altering the quantity of fluid in them, as evidenced by their change of shape. The rise in temperature on first taking alcohol was external, the internal temperature was not increased as the air exhaled was lower than normal. The increase externally depended upon a dilated condition of the vessels or radiation of heat, and therefore the process was one of cooling. Among the lower animals the only liquids that seemed essential were water and milk, and if we looked at the facts we should see that among the working classes, soldiers, and students, teetotalers would be found in the ranks of the hardest working men.

Mr. FRY thought it important to discuss the therapeutical use of alcohol in the wards. Mr. Carrington had not told them how and when to give alcohol, and to what class of patients. Dr. Wilks had said that alcohol was as much a medicine as quinine, and we should never get into a proper system until alcohol was given as a medicine, and the dose and mode of administration stated on the bed card.

Mr. PAUL described a case of hyperpyrexia, where instead of reducing the temperature, it seemed rather to increase it. No alcohol was found in the urine.

Mr. MCCARTHY, in speaking of the effect of climate, said that in cold regions alcohol was the reverse of beneficial, and the same might be said of hot regions in a district where yellow fever was raging: among those in the habit of eating largely and taking alcohol not one escaped, while many of them who only drank a little vinegar and water and no alcohol recovered.

Mr. MCKERN said alcohol ought not to be called a stimulant: it might give a little stimulus at the time, but it did not supply any store of force by which the stimulating action could be carried on. He thought that in Mr. Carrington's case, the success depended upon the nutritive principles contained in the wine rather than upon the alcohol.

Mr. DUKE remarked that the effect upon the urine produced by alcohol could not be accounted for except by supposing it accumulated. He had seen a case of typhoid most successfully treated by making the patient drunk with port wine. How did alcohol act as a poison? Did Mr. Carrington believe in spontaneous combustion as a result of alcohol drinkiug?

Mr. DAVEY described experiments upon animals which seemed to prove that there had been no accumulation of alcohol in the body. Dr. Anstie had given alcohol in proportion to the amount of urea found in the urine. Might not its effect upon the heart be due to its action on the pneumogastric?

Mr. AMPHLETT said they had the greatest difficulty in knowing when to prescribe alcohol, and when not. Certain cases were undoubtedly benefitted by it, as for example, cases of enteric fever with typhoid symptoms. The most opposite treatments of disease were indulged in. One person would treat a patient with vinegar and water, where others would give enormous quantities of nearly crude spirit.

Mr. CARRINGTON having briefly replied,

The Chairman called upon the Secretary to read the report of the Presidents upon the adjudication of the prizes. The report was as follows:—

The Presidents announce the successful prizemen to be—£10 to Mr. Symonds, for his paper on "Some Symptoms of Rheumatic Fever"; £5 to Mr. Hobson, for his paper, "Morbid Sounds of the Heart"; £5 to Mr. Carrington, for his paper on "Alcohol as a Food, Drug, or Poison"; £5 to Mr. Coley, for his success in the debates during the session. The report further states that the Presidents had decided to ask the following gentlemen to act as Presidents in the following year:—Messrs. Carrington, Coley, E. Duke, Davy, Elcum, Hobson, Lancaster, M'Carthy, J. Morgan, W.P.Reynolds, Shadwell, and Symonds.

Mr. CLARKE then rose to congratulate the prizemen. There had been considerable difficulty, he said, in awarding the prizes, as there were more than the usual number of papers above the average degree of merit. He briefly referred to the essays in detail, remarked on the satisfaction it would be to the coming competitors to remember that there was success in all honest endeavour, and that some victory was won in every gallant struggle that was made, and concluded by reminding the prizemen that they now looked to them in other paths and under other circumstances to uphold the status of the society.

Mr. Symonds and Mr. Carrington replied. Mr. Coley and Mr. Hobson were unfortunately absent.

Mr. PAUL asked them to join him in proposing a vote of thanks to the Treasurer. They had to thank him, not only for the use of the room, and for the warming and lighting, but more especially for the great interest he had ever personally taken in the society, both by his presence among them and his joining in their debates. He (Mr. Paul) regretted that absence from town prevented the Treasurer from being present among them that evening.

The proposal was seconded by Mr. M'Carthy, and carried by acclamation.

Mr. ELCUM rose to propose a vote of thanks to the Presidents on the conclusion of their labours for the session. Not only had they to adjudge the prizes, but when any stoppage occurred in the debates they stepped into the gap and helped them out.

The vote was seconded by Mr. Shadwell, and acknowledged by Mr. Chicken.

Mr. HARSANT proposed a vote of thanks to the Honorary Secretaries, Dr. Taylor and Mr. Lucas. The society, he said, could not be properly carried on if they did not have in their midst popular and respected Members of the Staff. It was a gratifying circumstance that among the hard-worked teachers of our school there should never have been wanting those who would come among them. Dr. Taylor had been honorary secretary now for three years, and during that time had introduced many alterations and improvements in the rules. Not less were they indebted to Mr. Lucas, who had done what no other man could have done—induced them to undertake the management of the *Gazette*. They are always ready to come forward and help them in matters connected with the society.

Dr. Taylor and Mr. Lucas, who were both received with great enthusiasm, replied.

Mr. FRY proposed a vote of thanks to their much-esteemed President, Mr. Cock. Mr. Cock had always taken the greatest interest in the society. He was its father, he had been present at its birth, and had dry-nursed it ever since. Mr. Cock had said this was the last link that bound him to the Hospital, and he was sure they would join with him in hoping that that link would not be broken for many many years.

Mr. Cock, who was received with prolonged cheering, said —I connot help rising without some feelings of emotion, for you are determined, I think, to kill me with your kindness. From the age of sixteen, when I became the articled apprentice of Sir Astley Cooper, my time has been spent in great measure at Guy's. And when a man has gone through every stage—from student to dresser, demonstrator, lecturer, assistant-surgeon and surgeon—and as one must at last, looks forward, by degrees he finds that the appointments can be better held by younger men. Few, however, have been so successful as I in retaining an appointment which, to judge from your expressions, has been as agreeable to you as to myself—that of Honorary President to this Society. I have little more to say than to thank you most sincerely for the good feeling I have always received from the students here, and to hope that as long as I have health and strength I may still come among you in the hospital, and, as consulting-surgeon, may from my experience and long life, add something of usefulness to that institution in which we all glory so much.

Report of a Case.

INFLAMMATORY THICKENING of FALX CEREBRI —MENINGITIS—ACUTE CEREBITIS—DEATH.

Family History.—Father and mother healthy. One son has had Rheumatic Fever twice. No history of tumour or consumption.

Personal History—The first symptom noticed was seven months ago, when she laughed without a cause at her mistress and was discharged for it. She was a nursemaid but could never bear the noise of the children. On leaving service she kept company with a young man who left her and this caused a mental shock. Since then she has been strange in her manner. Four months ago she began to suffer from incontinence of urine; this has continued since and the urine is now offensive smelling. Two months ago she lost the power of walking, she used to be helped up stairs at first, and then carried up. About this time she lost the power of talking, though she could occasionally speak perfectly well. When placed upright in a chair she would bend over till her head reached the ground. When spoken to she generally laughed. Appetite was voracious six weeks ago; since this she has eaten in the way described under present condition. She has complained of pain and aching in her limbs, more especially when warm in bed. She has menstruated regularly till the last three months; since then only once. No history of discharge from the ears, blow on the head, or severe pain in it, or headache.

On Admission.—She has taken a journey of thirty miles. Patient is a healthy looking woman with a good colour in her face. She has a peculiar stupid expression and when spoken to generally laughs. When asked a question she seems willing to answer, but unable to do so; she can, however, speak in a slow deliberate tone of voice and very low. When she eats she keeps the food in her mouth for an hour at a time and does'nt seem able to masticate her food. She can understand perfectly any questions put to her. There is no paralysis of either side of the face, and sight and hearing are unimpaired. She can protrude her tongue slightly and it is indented at the edges and covered with a white fur. Pupils generally dilated and equal, contract with light. There is a want of will in all her actions. Right side of body: When her right arm is placed vertically to the bed she retains it in this position for a great length of time, and can grasp firmly your fingers but has a difficulty in unloosening her hand. She can write words with her right hand, not with her left. The right side of her body has altogether more power than the left; the leg responds better to reflex action by a prick on the sole of the foot; the left leg also responds but to a less extent. She cannot hold her left arm up in the same way as the right. The right leg is generally moved over the left when the left is pinched. She has fits of jogging in her right leg; she can feel a pinch anywhere over the body. No heat of skin. She occasionally heaves a deep sigh. Bowels generally confined. She has had no motion while in the hospital. Heart: There is a thrill over the apex of the heart, but the chest walls are very thin. No bruit. Chest: Sounds and resonance normal.

February 20th.—She takes hardly any food while in the hospital. There is a bedsore coming over the sacrum. She is menstruating.

February 22nd.—Died this morning at 6.20 a.m. Yesterday she could not swallow. In the evening her temperature was 102 dg.

Post Mortem.—Head: The falx cerebri was rather adherent to the hemispheres and on its separation it was seen to be especially on its right face, thick and finely tuberculated by a yellow gelatinous granulation like a layer of new tissue, and on section of this layer and the sublying falx, it appeared that the opinion formed as to the nature of the thickening was correct. The falx was unchanged but lying upon it mostly on the right face, but also on the left was a layer of granulation tissue. The membranes of the brain in this region were yellow looking, thickened and adherent to the substance of the organ. This state was most decided anteriorly but extended back on the right side to the posterior part of the corpus callosum. The arteries of the brain looked quite normal. Elsewhere the membranes were perfectly healthy. They were neither greasy, nor tuberculated, nor opaque. Taking the right frontal lobe between the finger and thumb, it was felt to be decidedly indurated on comparison with the other side and still more so when compared with other parts of the brain. On section both sides, but especially the right, cut in the frontal lobes with that pecular gristly resistance found in cases of sclerosis. Throughout the whole brain this was more or less the case, but it was especially so at the anterior parts. On removing the upper part of each hemisphere nearly to the level of the corpus callosum, the cut section shewed a peculiar condition. The whole surface of both grey and white matter from the longitudinal fissure outwards as far as, but not involving, the grey matter of the external convolutions, and from the front to a little behind the fissure of Rolando posteriorly, the whole surface was of a brick red colour, most intense as far as the anterior part of the longitudinal fissure on the right side, i.e., where the granulation tissue on the falx was most decided. The left side in addition to the red tint was also soft, but on the right side it was hard. It was also noticeable that the grey matter of the various convolutions jutting into the brain from the longitudinal fissure was

nearly twice its proper thickness, swollen out: and it became quite impossible to define the outline of the convolutions, so perfectly did their outer border blend into the red tint of that in the white matter. On both sides the red tint was noticed from the surface down to the roof of each lateral ventricle and on the left side the roof of the ventricle was very soft. The corpus callosum was soft and the fornix also. The ventricles and other parts of the brain appeared perfectly healthy, the substance was firm, the cut section purplish in hue from engorgement of the vessels.

Examined microscopically the parts over the left lateral ventricle (red softening) had the usual appearance of soft brain tissue, i.e., numerous granule masses were seen and a generally corpuscular state of the brain substance. The tissue from the right side (red induration) shewed a remarkable absence of anything like nerve structure, but appeared to consist mostly of vessels and a dimly fibillated substance.

The medulla, pons and spinal cord were perfectly healthy.

The parts that were most diseased corresponded with the first and second frontal convolutions. The third was healthy on both sides. The disease extended further back than this in the white substance of each hemisphere, but the greater part on each side would be included in the anterior part of a brain divided vertically across from the commencement of one Sylvian fissure to the other, that is behind third frontal convolution on each side.

Weight of Brain 45oz. Venous blood in excess. Other organs healthy.

Remarks by Dr. Wilks.

When this girl was admitted the first impression made on the mind of the Clinical Clerk was that it was a case of hysteria. This idea was, of course, soon dismissed when the history was taken, and the symptoms were more clearly revealed. The first impression, however, was very natural and gives a clue to the whole character of the case, for it indicates that there were no striking paralytic symptoms present, and that the girl's manner was both lethargic and emotional. In fact she presented the symptoms which we sometimes see in extreme forms of hysteria. The history, however, showed that her illness began in a tolerably definite manner some weeks before, until she had reached the feeble state in which she was admitted. Then, as the report says, although there was some difference in the degree of power in certain parts of the body, there was no distinct paralysis as the term is usually understood. The inability to move appeared owing merely to a failure of the volitional act.

In true paralysis, the spinal system is affected, whilst the will is good, hence the patient is seen to make the greatest effort to move a leg or arm, although the result may be ineffectual. In disease of the brain proper, or during its functional elegance in hysteria, it is the will itself which fails; now it was evident that in this girl the power of acting or willing was gone. She made little effort to move, to speak, or even to masticate her food, and she allowed the bladder to empty itself in the bed. This latter fact removed the case from simple hysteria where the patient never allows herself to be inconvenienced in this way. She had not paralysis of the bladder, but simply as in mad people and in the lower animals, she exerted no intellectual control over it.

The patient had clearly, therefore, some progressive disease of the nervous system and the question was where was its seat and what was its nature. The absence of true paralysis shewed that the spinal system was not affected and by the spinal system is meant, not only the cord which is contained in the spinal canal, but the medulla oblongata, crura cerebi and central ganglia within the cranium. The disease, therefore, was in the brain proper and the opinion would make the disease coincide with the symtoms which were rather mental than physical. The question then was as to its being a tumour or a diffused inflammation. The former, as is known although localised may produce in an inexplicable manner a disturbance of the whole brain with a corresponding insanity, but at the same time it is usually accompanied by well defined symptoms as severe pain, sickness, convulsions, and amaurosis due to atrophy of the optic disc. It was, therefore, concluded that the disease was of a more diffused nature and largely involved the cineritious matter; it could be none other than inflammation or encephalitis, usually known by the name "red softening." It turned out to be an inflammation, but only a portion of the brain was soft, the greater part of the affected hemispheres being indurated from the effused lymph within it. A considerable part of both hemispheres were structurally destroyed.

In our present state of knowledge it may be said that when a patient has been ill only a short and well defined time with symptoms denoting a deep implication of his nervous symptom, and that no paralytic symptoms are present; it cannot be that his spinal system is affected, but his brain proper, viz., the hemispheres. She would of course lie in bed in a lethargic manner, having no will to move. Some time ago a young man lay in Stephen Ward for some weeks in a kind of torpid state, he never spoke, but his eyes wandered after objects as if he recognised every occurrence which took place. After death his whole brain was soft or pulpy.

A DISSECTION of the OBTURATOR NERVE.

By W. H. A. Jacobson and R. J. Pye-Smith.

In the following dissection the body is supposed to be in the supine position, with the left leg semi-flexed upon the thigh, which is abducted and rotated outwards.

The following incisions must be made in order to expose the whole course of the obturator nerve in the two distinct regions which it occupies, viz., the pelvis and the thigh:—

1. From within outwards across the inner side of the leg on a level with the tubercle of the tibia.

2. From the inner extremity of the above, along the inner margin of the thigh, upwards to the symphysis pubis, and from this continued upwards to an inch above the umbilicus.

3. From the upper extremity of the last outwards to the margin of the ribs.

The flap of skin thus raised being thrown outwards, the following structures must be removed in the same manner:

1. Superficial fascia over the whole area exposed. Between the two layers over Scarpa's triangle the following

structures will be included, viz.: The superficial branches of the femoral artery (superficial circumflex iliac, superficial epigastric, superior external pudic), the internal saphenous vein with the conjoined veins corresponding to the above arteries, the two sets of lymphatic glands (oblique and vertical), the ilio-inguinal nerve, the crural branch of the genito-crural nerve, the internal cutaneous nerve and a few twigs of the middle cutaneous nerve. The cremaster muscle, infundibuliform fascia and spermatic cord with its vessels, viz.: Spermatic, deferential, cremasteric and branch from superior external pudic arteries and veins, or (if female) the round ligament.

2. The fascia lata, cribriform fascia, Poupart's ligament, tendon of external oblique, intercolumnar fascia and Gimbernat's ligament.

3. The pyramidalis muscle (if present), the internal oblique and transversalis muscles with their conjoined tendon and the rectus muscle. The last three intercostal nerves and arteries and the ilio-hypogastric nerve.

4. The transversalis fascia and deep crural arch, the deep epigastric artery and veins, the sub-peritonæal tissue and the peritoneum.

The above structures being turned aside in a flap made by the incisions given above, the left part of the abdominal and pelvic cavities will be opened, and to expose the first part of the obturator nerve as it passes over the sacro-iliac synchondrosis—to which it perhaps gives a branch (Hilton)—and along the brim of the pelvis, it will be needful to remove the following (in part):

1. Peritoneum along the brim of the pelvis and over the intestines, including lateral false ligament of bladder and broad ligament of uterus.
2. Small intestines and messentery with branches of superior messenteric artery and vein and lymphatics.
3. Large intestine, viz.: commencement of rectum with meso-rectum and superior hæmorrhoidal vessels.
4. Vas deferens (or round ligament).
5. Obliterated hypogastric artery.
6. Ureter.
7. External iliac artery and vein and lymphatic vessels and glands.
8. Fascia iliaca.
9. Pelvic fascia.
10. Psoas magnus muscle.

On the thigh the following deeper parts must now be taken away in order to expose the superficial (anterior) division of the nerve, which gives branches to the hip-joint, pectineus (not constant), adductor longus, gracilis and adductor brevis muscles and to the femoral artery; it also communicates (in the "obturator plexus") with the internal cutaneous and saphenous nerves, and thus helps to supply the skin on the inner side of the knee, and should this cutaneous branch be large (taking the place of the inner branch of the internal cutaneous) it will be necessary to extend the skin flap half-way down the inner side of the leg.

1. Ascending (muscular) branch of internal circumflex artery, inferior external pudic and muscular branches of femoral artery, and their corresponding veins.
2. Pectineus muscle.*
3. Adductor longus muscle.
4. Pubic artery from epigastric and anastomosing branch between this and the obturator artery (or, if developed, the abnormal obturator artery).
5. Horizontal ramus of pubes.

Lastly, the following structures must be removed to expose the deep (posterior) division of the nerve which gives branches to the obturator externus, adductor magnus and (sometimes) adductor brevis, and to the knee-joint and popliteal artery.

1. A few fibres of the obturator externus.
2. The first and second perforating arteries.
3. The adductor brevis, and (to trace the articular branch).
4. A few fibres of the adductor magnus.
5. The sartorius, and
6. The internal saphenous nerve at the knee.

* This will be sufficient to expose the accessory obturator nerve, if present, giving branches to the hip-joint, and usually to the pectineus and anterior division of the obturator nerve.

MATERNITY CHARITY.

Statistical Report for February, 1875.

Total of women attended, 193: Single births, 190; twin cases, 2; abortion at three months, 1.

Total number of children, 194: of these 101 were males, 93 living and 8 stillborn; 93 were females, 88 living and 5 stillborn,

Presentations: Vertex, 183; breech, 5; foot, 2; face, 3; placenta with vertex, 1.

Operations: Forceps, 2; version, 1; embryulcia, 1.

There were no maternal deaths.

Of the women attended there were, in their

1st confinement		...	...	24
2nd	,,	...	...	30
3rd	,,	...	...	24
4th	,,	...	...	33
5th	,,	...	..	25
6th	,,	...	...	13
7th	,,	...	...	14
8th	,,	...	...	11
9th	,,	...	...	3
10th	,,	...	...	8
11th	,,	...	...	4
12th	,,	...	...	1
13th	,,	...	...	2
15th	,,	...	...	1

Thos. S. Morley,
Senior in Charity.

Received.—The London Medical Record, The Sanitary Record, The Medical Enquirer. Communications from Dr. Moxon and Dr. Pye-Smith.

The Presidents of the Physical Society respectfully acknowledge the receipt of Honorary Subscriptions from Dr. Debus £1 1s., and Mr. Higgens, £1 1s.

We are compelled to omit the accounts of Operations, the Surgery, and the Wards.

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Guy's

Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 26. SATURDAY, APRIL 3, 1875, TWOPENCE

AMONG the few who have joined in the recent noisy clamour against Vivisection and who have any claim to be heard with patience by physiologists are Mr. CONGREVE and Dr. BRIDGER, who have expressed their opinions in a temperately-worded article in a recent number of the "Fortnightly Review." They are both of them presumably acquainted with the importance of physiological research, and the great benefits already derived from its very imperfect prosecution, and both of them occupy positions in which they cannot be accused of any Exeter Hall tendencies, or of sympathising very heartily with the "sentimentality" of the *Spectator*. They approach the subject from a different stand-point: they object to it, not so much on sentimental ground, but they seem to think that but little good can come from the study of isolated physiological questions. They join, however, those who denounce physiological laboratories, and who would deny to Physiology its position as an experimental science. They prefer that the student should gain his knowledge second-hand, not so much out of regard for animal life and suffering thus saved, but because, to use their own words "the reliance on this visual observation so loudly urged at present has we think a tendency to weaken the higher powers of the mind to interfere with the reasoning process in its more active form." They would seek to place Physiology, not on a level with Experimental Physics, but with "social science" where experiment in the strict sense is out of place.

We who are less adepts in the reasoning process than the author of "Essays: Political, Social, and Religious," and who humbly strive as clinical observers in the wards to apply the lessons learnt by physiological demonstration, and who are conscious we too often fail because we know too little of physiological processes,—that the questions presenting themselves for solution by the bedside are often questions to be answered more by the practical physiologist than the physician, may be excused if we have but little patience with this "social science," but look rather to the more practical methods of direct investigation of Nature by observation and experiment.

They make some exception, however, in favour of original research, but seem to think that the knowledge already gained is an excuse for resting on our oars instead of an earnest of the prizes to be gained in a vast and unknown promised land.

They assume, with the most rabid anti-vivisector, that physiological experiment means untold animal-suffering, and they shrink with horror from experiments calculated only to add to the hardening process of intellectual training." It is needless for us to point out that at any rate in a hospital like this, thanks to anæsthetics, animal-suffering must be small indeed, that it exists only in the imagination of some amiable and yet excitable minds.

But it is evident that the great objections raised by our authors have been urged on different grounds to those of the majority of noisy agitators. In their eyes the study of experimental Physiology is "a misdirection of the energies alike of the biologist and of the physician." They hardly indicate

to us why, and we have neither time nor taste to follow their mysticisms.

We regret the part they have taken. In the eyes of the public their opinions will have more influence than they merit, but we cannot believe they will have any weight with those best calculated to judge.

We believe in all seriousness that there is a vast field for experimental research in the investigation of the mysterious processes of life, results of the greatest importance to be obtained at a minimum of suffering to the lower animals and fraught with the greatest benefit for the lessening of the evils and the ills of human life. We feel tolerably sure that Practical Physiology, conducted by humane experimentalists is safe alike from the assaults of ignorant excitable enthusiasts of the pious kind, and the mysterious philosophy of the disciples of Positivism.

A STUDENT'S NOTES OF

Lectures on Midwifery.

By J. Braxton Hicks, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

Lecture XX.

Rupture of the Perinæum.—But irrespective of unnatural rigidity in the perineæum, this part may be unduly on the stretch during the descent of the head, in consequence of its great size, or want of due moulding during its descent through the cavity; or by the acuteness of the angle of the pubic arch, whereby the head being driven back towards the coccyx, presses severely on the edge of the perinæum, and this trouble is liable to be greater when the coccyx is, as in some pelves, too little curved forwards at its tip, and thus the direction it should give forward is lost.

With regard to the great size of the head, it must always be borne in mind that there is a limit to the elasticity of the soft parts, and that this being exceeded a rent must ensue. If the head be very large, of course we must use the means to relax the passage as much as possible, as suggested in talking of "Rigid Perinæum," and should the pains be not sufficient, then with care we may employ traction by the forceps, &c.; but when the elasticity of the parts is carried to the utmost there is imminent chance of rupture. Although we are blameable, if, short of this, we allow the rupture to take place from want of measures tending to relaxation, yet there are evidently many cases which are unavoidable, and it is always advisable in difficulty of this kind, to mention to the friend who may be in the room or the attendant, that we fear that in spite of the utmost care, a crack may ensue; either this must occur, or the parts must be divided at each side, or the head must be lessened. Now, with regard to perforation, I have no hesitation in saying that we have not the slightest justification in performing it for obstacle in the perinæum only. Life for life, but not for a possible rupture in the soft parts, because first of all it is never absolutely certain that rupture will occur till the head is actually born; and secondly we have now at command operations for the closure of the rent, either directly after, or by a subsequent plastic operation, that we have no excuse in following the plan formerly recommended of sacrificing the child.

With regard to the head passing down the vulva before it has been duly moulded, we see instances of this in large pelves, and in cases where, especially in primaparæ, the head has been drawn down rapidly by the forceps. Doubtless those are right in this point of view who recommend us not to be so very quick in employing the forceps; some advantage is gained by the prolongation of labour in this particular, as well as in the complete and persistent irritation set up so as to procure good subsequent contraction.

Again, in regard to the narrow pelvic arch. As in the masculine or male shaped pelvis, rupture is not infrequent, and in our attempts to restore the perinæum we must bear this in mind, because making it too natural, the next labour may undo that work of which we were not wisely proud.

Now, I have heard old practitioners say they have never had a ruptured perinæum. I am very incredulous. I have thought the same in some of my own cases, where I had taken the greatest time and care, and would have disbelievd any one who had told me that there was a ruptnre; but I had the curiosity to look, and found the contrary. It is well always to examine digitally, or if any doubt occur, optically. In cases of extreme distension of the soft outlet it is well to pass in plenty of lard or similar lubricant, as far up as possible, and especially in protracted labour, because the mucus becoming scanty the head ruckles up the inner layer of the perinæum, and thus there is a tendency to abrade if not to cause laceration of the mucous membrane.

The direction of the rupture is generally from the middle of the posterior fourchette backwards towards the anus. Its distance varies, it may be only half the space between the sphincter ani and the edge; or it may extend down to the sphincter running up the recto-vaginal septum an inch or so, thus totally preventing the action of this muscle, incontinence of fæces following. Or what is much better, it may come down to the sphincter, and, instead of passing through it, may dissect right and left of it, to the extent of an inch or two either side. This makes a large gaping rent, but is vastly better than when it passes into the rectum.

But it does not always rend the margin, for it has happened that the ostium vaginæ is very firm and dense and the arch of the pubis small, so that the force of the pressure is thrown on the centre of the perinæum so that it yields, the child passing through it. I have never seen any case myself of it, but I have thought in one or two cases that it must happen.

Supposing, then, the perinæum ruptured, how should you treat it? If only half the distance between edge and sphincter be torn, leave it alone, keep the parts clean, inject the vagina with Condy's fluid or carbolic lotion daily. It will close sufficiently for all purposes. If it have reached the sphincter, then put in one stitch about half an inch from the bottom. Let the needle enter at least half an inch from the margin of the rent. I prefer three-quarters of an inch away. Use a stout silver suture or a well-

waxed silk one. If the extension has taken place right and left, dissecting out the sphincter, then put in two stitches, one near the angle of the rent, and the other nearer the vulva. But if it have gone through the sphincter, then much care in adapting the edges must be taken. The first stitch should be made to include the sphincter. The needle should be made to enter three-quarters of an inch from the margin of the rent, should be passed deeply upward between the layers of the recto-vaginal septum to the innermost portion of the rent, and brought out again in the same position on the opposite side. Then another stitch should be made about three-quarters of an inch in front of this. Two are sufficient, if well inserted. The sutures should be of stout silver wire; if too small size is used, it cuts through before the parts are sound. They may be brought together by simple twisting, or as in the "quill-suture" plan; in either case allowance must be made for subsequent swelling. The sutures should not be put in till the placenta is away and chances of flooding subsided. They should be well cleansed; and it is best to leave plenty of end on, in case subsequent flooding require the introduction of the hand, when the twist can be undone and the rent laid open. It is proper to inject out the vagina twice a day after, with some antiseptic lotion. The urine should be drawn off for some days and the bowels kept quiet for five days when an enema may be given, and repeated. It is best to leave the sutures in till the bowels are open properly as they will support the newly adherent parts. Generally, but not invariably, primary union is secured, but if not if the sutures have not ulcerated out they should be retained so as to try and secure union by granulation. This I have not infrequently seen a successful plan, when others had given up the case for a time. I have also, when the rupture had occurred some days previous, put in sutures on the chance, and the parts have been healed. In one case perfect union took place although five days had elapsed since the labour. After a week or ten days union will be perfect in most cases and the wires may be taken out. In the case of quill-suture, as indeed in the others the tension may be great from the swelling; then the sutures must be untwisted and eased a little. Under the "quills" the secretions are apt to lodge, and these must be carefully cleansed; personally I do not like this form of suture, for this accident. Opium must be given two or three times a day to secure quietude of system and sphincter, and the patient must be advised not to draw up the parts, as they are apt to do to relieve the discomfort.

In cases where the rent is considerable but no suture used, it is well to instruct the patient not to spread open the legs; in fact to remain quiet for a greater time than usual.

RESIDENTS FOR APRIL.

House Physicians ...	...	Messrs. Fry and Clarke
House Surgeon ...	...	Mr. H. Williams
Senior in the Charity	...	Mr. D. B. Lees
Junior in the Charity	..	Mr. H. N. Smith

Mr. Forty is Junior House Surgeon.

Clinical Lecture.

ON ACUTE PNEUMONIA.

Which should have been delivered on March 20th,

By Dr. Moxon.

Without Pathological Anatomy we should be in the dark, as we think our fathers were.

Believing this, I am not likely to speak disparagingly of it.

Yet I did grow in a way dissatisfied with it when I came to feel directly the responsiblities of medical practice. Because it did not often tell me in unsuccessful cases why it was that the patients died. And especially why they died at that particular stage which had proved fatal.

That is the question which we want solved. *Why did the patient die?* It is not enough to open the body and look and pronounce "Pneumonia." This, if I may say so, is too often assumed to suffice; nay, men use commendatory phrases and say "Splendid example" of acute pneumonia. That may be very attractive and edificatory in its way, but I am not satisfied. I want to know why it became a splendid post-mortem example at all. Why was it not a splendid cure?

The pathologist fails to show you a measure of pneumonia which he can compare against a measure of life-power, and prove that the pneumonia was longer, broader, weightier than the vitality. Yet that is the problem. Without a solution of that question the P.M. Room becomes a Slough of Despond and pneumonia suggests death to you, Yet you see it alive in the wards. What unites the dead and the living pneumonia? To be penumonic is not to be doomed to die. Far from it, thus Dr. Hughes Bennett says that of 103 cases, 20 of which were double and 15 involving the whole of one lung, not one uncomplicated case died. This would make you believe pneumonia to be purely benignant. But while quoting this to show a view of good hope, I must not leave you with the impression that such is an average experience of the fatality of pneumonia. Quite otherwise, as follows:—Austin Flint says, of 133 cases 26 per cent. died. Drasch, 3—25 per cent. Griesinger, of 31 adults with pulse 120 and upwards, 10 died. Roth had a mortality of 20 per cent. Brande puts little confidence in statistics, for in the same wards and with the same treatment, 5½ per cent. died in 1856 and 31 per cent. in 1857. These accounts will give you a more correct view of the degree of danger which pneumonia brings with it, but as we shall presently see. age and circumstances of nursing, care, &c., as well as from Brande's important remark, the current gravity of the disease bring very significant differences in this all important branch of the history of pneumonia.

We must evidently extend our enquiry beyond mere morbid anatomy if we are to estimate the risks, and understand the management of pneumonia. But we must not despair of help from morbid anatomy. For by its aid the first requirements in considering what we have to deal with in the various inflammations of the lung are supplied. It has given clearness to the distinction between true or primary and false or secondary pneumonia.

When we speak of true acute primary pneumonia as a

clinical disease, we mean a very distinct kind of disorder itself including varieties, but clearly separated from other secondary disease for which the name pneumonia is pathologically used. First, it is very distinct from "chronic pneumonia." We are apt to go away with the impression that chronic is to acute pneumonia as the same thing only diluted with time, as tincture of lavender might be diluted with water. The fact is that the two diseases are extremely different, thus test them only by their effects. Chronic pneumonia is a disease that forms hard tissue in the lung; acute pneumonia never does anything of the sort. It is something like with hot and cold water; hot water mixed with cold water seems merely diluted, but it is for some purposes quite a new thing; for instance, very different if you want to boil eggs. The cooled water won't boil eggs more slowly, it won't boil eggs at all. And chronic pneumonia does not produce in the blood those fever dangers we shall have to allude to. It leads to death by slow exhaustion except that acute pneumonia may at any time light up in it, and here, in this matter of ready transformation, is the nearest real relation between chronic and acute pneumonia.

The *acute* diseases that are called pneumonia are so widely different in clinical nature that we cannot too soon or too prominently hold out their distinctions to view. Shortly, the kinds of pneumonia that contrast with acute croupous pneumonia are these:—

(1.) *Catarrhal pneumonia*, arising consecutively upon bronchitis, and found in small patches about the ends of the bronchia, not coming to the surface and so with no pleurisy. Met with in croup, whooping-cough, fevers, influenza, pressure on root of lung, &c.

(2.) *Tuberculous pneumonia*, or acute inflammatory phthisis, some think this the same as the last, but they overlook one of the widest distinctions in the nosology; at least, I believe they do. It begins at or near the apex and extends downwards, and it leads to destruction of the tissue. These characters distinguish it from catarrhal pneumonia.

(3.) *Pyæmic pneumonia* occurs at the surface of the lung, and chiefly in the lower lobes and with intense congestion around the patches, it inflames the pleura and destroys the texture.

(4.) *Hypostatic pneumonia* resembles catarrhal pneumonia, of which it is a variety indeed; yet requiring distinction: found in the dependent parts of the lungs in states of febrile exhaustion, and appearing as scattered lobular patches with much passive stagnant congestion around. It is probably, largely due to careless feeding and imperfect swallowing, such as introduces irritant food into the trachea, which gravitates to the bases, or else due to collection of semi-putrescent mucoid bronchial products which the patient is too feeble to expel.

All these kinds of pneumonia are broadly distinguished from true primary acute pneumonia, in this at once, they are all *lobular* in extent, and form little discreta and scattered patches of inflammatory change. True pneumonia differs from them all. It is an original, sudden, and general disorder of a large tract of the lung's substance. It is known as *Lobar* or *Croupous* Pneumonia, both titles signifying really important features of it.

Lobar-*extent*. It is astonishing to find how much new matter may form or be poured out. I have found the lung much more than three pounds heavier than natural. Now when you remember that a hæmorrhage of three or four pounds is near the average of a fatal loss in cases of aneurisms bursting in the abdominal cavity, the pneumonia becomes evidently very grave if only as a withdrawal of matter from the circulation. But it is more than loss. For if you look with the microscope at the substance poured out, you find it is partly growth, crowds of lymphoid cells being present. Some would regard these cells as escaped from the vessels—outwandered leucocytes—but there appear to be many times more of them than the whole blood in the body contains, and meantime the blood rather contains too many than too few, so that evidently there is new formation or growth of these elements, a sort of low fungation which it is impossible to doubt must exhaust vital power in its wastefully profuse evolution.

Croupous. This name belongs to Rokintansky's theory of "crasis"; he thought the several sorts of inflammatory products responded to states of fibrin in the blood, and named one of these "croupous." It has nothing at all to do with true croup. Croup of the trachea leads to catarrhal pneumonia, if any.

This "croupous fibrin" fills up the lungs, and that appears clearly a very dangerous thing, for it threatens suffocation. Do people die in pneumonia because they cannot get breath enough; die, that is, of carbonic acid poisoning? Well, not very often, and not very evidently even then. The surprise is the other way. If death were due to closure of the lungs by the fibrin we could measure the mischief post-mortem with unfailing certainty; but you will not see many P.M.'s on pneumonia without being struck with the great variety of extent of inflamed lung, which is required to kill different subjects.

No! the dangers that reveal themselves as the patient begins to flag are of other kinds than this simply mechanical one, and you will be also surprised to see how quickly they "pick up" as soon as the pneumonic *action* ceases, though the *products* are as plentiful as ever. The mortal dangers of pneumonia cannot usually be appreciated in the dead-house. They must be seen at the bedside.

(*To be continued.*)

NOTES ON HISTOLOGY.

(From Dr. Pye-Smith's Demonstrations of Practical Physiology.)

(Continued from page 186.)

Epithelium.—The first group of "tissues" is defined as *made up by the aggregation of cells*. It includes epithelium in all its forms: the epithelium (in the limited sense of the word) of mucous membranes, and of secreting glands; the "endothelium" of serous and synovial membranes, of blood vessels and lymphatics; the epidermis of the skin, with nails and hair; and lastly the crystalline lens and possibly the enamel of the teeth should be included under the group of epithelial tissues.

Epithelial cells may be classified from several points of view.

(1.) *Shape*. Those first formed are like all young cells—like those of the embryo and like blood-corpuscles—*spheroidal* and soft. Hence such are usually found in the deeper layers of epithelium, and are characteristic of the acini of secreting glands.

When these cells grow close together in a single layer and

the lateral pressure is greater than the vertical, they assume a cylindrical or *columnar* form, like the parenchymatous cells of a growing root; and sometimes their nuclei are pushed alternately up and down for mutual accommodation. The cylinders either retain their circular transverse shape or are squeezed into square, hexagonal or irregular prisms.

If the vertical pressure is greater than the lateral the cells become flattened disks. In a single layer they usually assume either a regular hexagonal form like the "cells" of a honeycomb, or a sinuous interlocking outline like the epidermis of many leaves. Such epithelium has been compared to a pavement and called *tessellated*. When there are several layers, the arrangement is less regular, the flat disks are more round or oval, they are piled one on another like slates and are known as scaly or *squamous* epithelial cells.

But the epithelium of many organs cannot be arranged under the preceding heads and must be described as irregular, or transitional, or peculiar. Such are the prickle or hedgehog-cells found in the deeper layers of the tongue, the imbricated cylinders which line the ascending siphon-tubes of the kidney, the irregular squamous cells found in the bladder and in carcinomata, and the bird's-nest aggregations which, though usually, appear not to be exclusively morbid.

(2.) *Size.* The smallest spheroidal epithelial cells are scarcely larger than white blood-corpuscles. The diameter of the largest squamous cells of the skin or of the tongue is twice the length of a frog's blood-disk, i.e., they are five times bigger than they were when first formed in the deepest part of their epithelium.

(3.) *Consistence and chemical contents.* Epithelial cells lose the power of movement, but vary in their mode of nutrition. Thus the youngest cells are soft, thin-walled, nucleated masses of protoplasm. Old squamous cells, on the surface of the skin, from the nails, or the hair, become hard and converted into *horn*, (ceratin). The hexagonal tessellated epithelium of the choroid becomes filled with *pigment* (containing N with excess of C); the spheroidal epithelium of the liver with pigment or with molecules or with drops of *oil*: and the secreting cells of the pancreas, kidney, and of glands generally, with the special material which they select from the blood, and this gives the characteristic *granular* appearance of glandular epithelium. Lastly the spheroidal epithelial cells of the seminiferous tubules are not only granular from amorphous secretion, but contain manufactured products of definite structure, the spermatozoa.

(4.) *Appendages.* An epithelial cell may have a tapering root-like process by which it fixes itself to the subjacent tissues, as with many columnar cells, or a long vibratile flagellum. But the most important appendages are *cilia*. These are minute processes of protoplasm which pierce the cell-wall and are in constant to and fro movement. The contractile power of the whole cell is confined to these cilia and (as usually results from such "differentiation") is more rapid and powerful for its limitation. They may grow on spheroidal cells, as in the frog's mouth, or on squamous, as in the ventricles of the brain, but in man they are usually found on columnare pithelium.

(5.) *Origin.* Each of the three primitive layers of the embryo gives birth to epithelium.

From the *epiblast* or outer layer is formed all that of the skin, including hairs, nails and sebaceous and sudoriparous glands: also the epithelium of the conjunctiva, of the nasal fossæ, of the tongue, of the mouth as far as the fauces' with the salivary and mucous glands, of the external meatus and tympanum, of the lower part of the rectum, of the central canal of the spinal cord and the ventricular cavity of the brain, the crystalline rods of the lens, the hexagonal pigment cells of the choroid, and lastly the squamous epithelium of the amnion. To all these the term *epidermis* may be strictly applied, though it is commonly used only for those parts which form the external skin in the adult.

From the *hypoblast* or lower layer of the embryo is formed the epithelium of the pharynx and œsophagus, the pituitary body (?), the epithelium of the œsophagus stomach and intestines, with that of their various secreting glands including the pancreas and the liver, also that of the lungs (except perhaps what lines the air-vesicles), of the thyroid (?), of the bladder, urachus and allantois, and lastly of the yelk sac and the ductus vitellinus. These structures are called "*epithelium*" in the restricted sense of the word.

From the *mesoblast*, or middle embryonic layer comes the epithelium lining the pleural and peritoneal cavities, both visceral and parietal, that of the pericardium, and the tunica vaginalis, of the endocardium, the inner coat of blood-vessels and lymphatics, and of all synovial membranes. In fact except in the uro-genital organs, whose epithelium is certainly in part derived from the mesoblast, all the epithelium which does not form glands belongs to the mesoblast. The name *endothelium* has been generally adopted for this third class of epithelium.

Examples. Saliva: squamous and spheroidal (salivary) epithelium. Scraping of hand. Shaving of nail: add potash. Hair with its bulb; human, and from mouse, rabbit, cat, &c. Ciliated epithelium of frog in salt solution: effect of water and of weak alkalies. Columnar cells of fresh intestine. Hexagonal tesselated epidermis of frog. Pigment cells of choroid of ox. Glandular cells of fresh liver. Epithelium of pig's bladder. Endothelium of frog's mesentery stained with silver. Serrated fibres and rods of crystalline lens, fresh and after boiling.

Correspondence.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents.]

To the Editor.

Sir,—I have often wondered whether it has ever struck the Guy's men that a great compliment might be paid to one of our oldest and *best* teachers, viz., Dr. A. S. Taylor. He has now been connected with Guy's Hospital for about fifty-two years. During the latter part of this time he has furnished us with a vast amount of useful and scientific knowledge. There must come a time when he will give up lecturing, and then we shall miss him *much, very much.* As all know how clear his teaching has been, surely a good portrait to put in the hospital would be the greatest honour we could pay him and his family.

Should this little hint be the means of a subscription list appearing, I shall most willingly add my mite.

I remain, Sir,

A Well-wishing Old Guy's Man.

London, March 18, 1875.

Obstetrics.

C. C., æt. 22, was confined March 20th. Went on well, only complaining of slight uneasiness in the abdomen until the morning of 25th, when she suddenly felt pain in the lower part of abdomen which doubled her up. At 9 a.m. was still in great pain. Abdomen tender, especially over uterus. Tongue furred. Temp. 102, pulse 144. ℞ Opium gr. j. 10 a.m.—Quiet, under influence of opium. Milk abundant, starts at times. 5 p.m.—Has wandered much, talking of child. Answers questions, never volunteers to speak. Temp. 101·7, pulse 156, small and weak. 7.45 p.m.—Temp. 103·4, pulse 160. Very offensive discharge from vagina, syringed out with Condy. In no pain. 10.30 p.m.—Wanders still. Breasts tender and distended. Temp. 103·6, pulse 156. Lies with knees drawn up. Complains of headache. Replies to questions. Tongue furred and pointed. Never asks after child. ℞ Quin. sulph. gr. x. statim., mist. spiritus vini gallici ʒ j.. every hour, opium gr. j. at 12.30, 6.30, and 11.30 p.m.

March 26th.—9 a.m.—No sleep. Remained quiet, but often started. Temp. 102, pulse 136, feeble. Syringed. 3 p.m.—Temp. 101·6, pulse 148. Lips of uterus feel large, swollen, and glazed. Vagina hot. Discharge offensive. Syringed out a decomposed blood-clot from uterus. Picks at the clothes, and tries to raise the patterns off the wall. Bites her lips and nails, as if irritated. 8 p.m.—Temp. 100·8, pulse 144. Expresses herself as much better. Asked if she would recover. Asked for the baby, but when it came she pinched its cheeks and arms, and pushed it from her. Remembers everything. Takes quinine in powder, gr. v. every two hours, and keeps it down. 11 p.m.—Temp. 100·1, pulse 132. No abdominal pain. Breasts distended, discharge very offensive.

March 27th.—Slept from 12 a.m. till 4 a.m., starting occasionally. 4 a.m.—Temp. 100·7, pulse 128. Seemed refreshed, took a powder and some milk. 10.30 a.m.—Temp. 99·9, pulse 132. Bowels open twice, motions not offensive, pale. 8 p.m.—Temp. 99·6, pulse 109. Syringed out three times to-day, discharge very offensive. Saw baby to-day, seemed a little pleased.

March 28th—10 a.m.—Temp. 99·6, pulse 103, slept all night. Expresses herself as much better. Seldom inquires for baby. Dischargs still offensive, but vagina feels firmer, the lips of os less swollen and firmer. 6 p.m.—Temp. 101·7, pulse 120. Right breast painful, throbbing and hard. Her friends have been disturbing her. 10 p.m.—Temp. 100·3. pulse 120, after syringing pulse was 103.

March 29th—9·30 a.m.—Temp. 99·8, pulse 124. Comfortable night. After syringing pulse was 118. 7.30 p.m.—Temp. 101·5, pulse 126. Right breast still painful and hard. Was pleased at seeing the baby. Asks questions, and talks more than she did.

March 30th—12.30 p.m.—Temp. 98·6, pulse 124. Had a comfortable night. Discharge less offensive. After syringing pulse was 106. 9.45 p.m.—Temp. 100·5, pulse 112, after syringing the pulse was 106.

March 31st—9·45 a.m.—Temp. 98·9, pulse 116. Passed a good night. The vagina has contracted so that now it is difficult to syringe the uterus without pain. 10·45 p.m.—Temp. 100·8, pulse 124. An abscess forming in breast.

April 1st—11 a.m.—Temp. 99·6, pulse 99. Has the baby altogether now. The latter part of the Condy injected is not discoloured. Still continues to take small doses of quinine. Has always taken plenty of milk and beef tea. 9 p.m.—Temp. 100·2, pulse 98. Less discharge from vagina. Uterus small and firm.

The cause of the trouble was the decomposition of a clot in the uterus, which was brought away by syringing. This puerperal condition was not contagious, as patients attended subsequently are doing well. On several occasions the pulse fell after syringing, though the patient had been moved about a goed deal. Great care was taken to have the room well aired, the window and door being opened several times a day.

The Surgery.

We have to acknowledge the addition of one very valuable sign of sub-glenoid dislocation of the shoulder-joint, omitted from the signs of this injury, as given in a late number of the *Gazette*, and noticed in the letter from "An Old H. S.," in the number for the 20th ult., namely lengthening of the arm to the extent of from one inch to an inch and a half. Fortunately this point has been very clearly demonstrated since then, for on the 22d ult. two cases of dislocation of the shoulder were treated: in the first, the displacement was downwards into the axilla, sub-glenoid; in the second, the head of the bone was displaced forwards the coracoid process, sub-coracoid. In both there was an increase of nearly two inches in the vertical circumference of the shoulder; in both the depths of the anterior boundary of the axilla was increased, though to a greater extent in the sub-glenoid than in the sub-coracoid. There was an increase of one inch in the length of the arm in the sub-glenhid, while in the other case there was no alteration in the length of the arm.

The first case was reduced by extension of the arm with the knee in the axilla; the second case was reduced by manipulation, in neither case was any anæsthetic given. The after treatment was alike in both cases, and consisted simply of keeping the arm fixed to the side by means of a flannel roller.

There hats also been one case of fractured humerus in a man, aged 25.

Two cases of epistaxis have been treated, in both it was necessary to plug the posterior nares. On examination the urine of these two patients in both instances albumen was found.

On March 20th, a boy aged 20 came up with a sore on the point of his elbow, and absorbent inflammation affecting the axillary glands; the glands over the inner condyle and in the axilla were swollen and tender, very distinct red lines ran from the sore place on the elbow to the armpit, and the patient complained of a good deal of pain. A solution of nitrate of silver, one drachm to the ounce of water was freely applied along the course of the red line, a good purge given, and iron and cinchonine mixture ordered.

On March 23rd the pain was gone, and the red lines along the arm had quite disappeared, the only remains of the trouble being two or three slightly enlarged glands over the inner condyle and in the axilla. The use of a strong solution of nitrate of silver, applied in the course of the

inflamed lymphatics in the cases cannot be too highly recommended. We have seen it act in a most charming manner on more than one occasion; one caution is, however, necessary in its use, and that is not to apply the solution too freely as very unpleasant vesication may be produced if some caution is not used.

We have had one case of compound dislocation of the terminal phalanx of the thumb; the bone was displaced backwards and inwards from a fall upon the point of the thumb. Reduction was easily effected by simple extension; the wound was dressed with compound tincture of benzoin, and a small zinc splint applied along the palmar surface of the thumb. In addition to the above there has been one case of dislocation of the second phalanx of index finger forwards, which was easily reduced by extension; and one case of compound fracture of the ungual phalanx of the thumb, which was dressed with compound tincture of benzoni and put up on a small zinc splint.

Both the cases of diffuse palmar suppuration reported in a recent *Gazette* are now in the hospital; in both, incisions have been made in the arm, above the annular ligament, and both are now progressing favourably. In one of these cases the pain was most extreme over the distribution of the median nerve, no doubt due to the fact that this nerve was compressed by the pus effused beneath the deep fascia.

Operations.

Friday, March 19.

Last Friday Mr. Bryant operated for ununited fracture of the humerus. The bones had been previously drilled and pegged without permanent success, and subsequently the ends had been resected and a wire suture used, but with similar ill success. The arm was a mere flail. Mr. Bryant resected the ends and fixed them together by silver wire after drilling. The arm was put up on an inside angular splint with a moulded leather splint on the outside.

Mr. Mitchell, (Mr. Bryant's dresser) excised an ephithelioma of the lower lip on Monday.

Tuesday, March 22.

On Tuesday Mr. Bryant excised a parotid tumour. It proved to be cartilaginous.

Mr. Birkett removed the breast of a woman æt. 52. She had only noticed the tumour four months and during that time it had increased rapidly, but had not involved the skin or glands. After removal it was found to be a cystic sarcoma. Some of the cysts contained a dark coloured fluid, and intra-cystic growths, but were not of large size. It was supposed before removal to be probably a carcinoma, but certain diagnoses could not be made. She was married, but sterile, and Mr. Birkett remarked that many of these cystic sarcomas occur in sterile women.

A man from Lazarus was next brought into the theatre. He had a severe compound fracture of the left leg two years ago, and probably on account of the inflammation extending up the muscles, these had been matted together and so movement in knee and ankle was very slight. He was put under chloroform and Mr. Birkett attempted to break down the adhesions forcibly, but his efforts were not rewarded by much success. Although some adhesions gave way, the knee was not brought to a right angle,

Tuesday, March 30th.

Mr. Birkett operated for stone on a boy, æt. 3. Symptoms had only been noticed for six months. The lateral operation was performed after Key's method, but Mr. Birkett used a modification of his staff, it having a greater curve than Key's. The stone was a large one, being one-quarter of an inch in its longest diameter, and three-quarters of an inch in its shortest. It had an irregular coating of phosphates, but a section was not made. From its size it must have been forming since birth. Before the operation it could be felt through the abdominal parieties elevating it with the sound.

The Wards.

The following Cases were admitted between March 24 and March 31.

MEDICAL.

Philip.—6—Kyphosis—bronchitis. 6—Enterica. 13—Ague. 17—Bronchitis. 21—Enterica—bronchitis. 31—Cirrhosis. 36—Aortic disease. 40—Mediastinal tumour. 47—Hemiplegia.

Bright.—5—Morbus cordis. 10—Bronchitis—albuminuria. 19—Phthisis. 20—Epistaxis. 21—Mitral systolic.

Addison.—22—Chlorosis. 25—Albuminuria.

Stephen.—26—Bronchitis—emphysema. 38—Albuminuria.

Mary.—4—Ascites. 21—Pneumonia.

John.—12—Morbus cordis. 17—Morbus Addisonii.

Miriam.—17—Chorea. 21—Morbus cordis.

SURGICAL.

Dresser for the week, Mr. W. Cock.

Late Dresser for the week, Mr. R. C. Richards

Cornelius.—1—Fractured tibia and fibula. 3—Fractured tibia and fibula. 5—Fractured tibia and fibula. 8—Fractured tibia and fibula. 10—Scalp wound. 11—Fractured tibia and fibula. 13—Fractured tibia and fibula. 15—Compound comminuted fracture of humerus—amputation. 17—Fractured tibia and fibula. 22—Fractured tibia and fibula. 25—Wound of leg. 26—Compound comminuted fractured left leg—amputation.

Accident.—Fractured base. Injury to ribs. Scalp wound.

Job.—17—Chronic disease of knee—incision. Disease of tarsus. Disease of humerus.

Naaman—8—Fractured fibula 20—Spindle-celled sarcoma of hand, second removal. Refractured patella. Fractured fibula. Ulcer of leg

Luke—3—Anchylosis of shoulder 4—Stricture, retention of urine 5—Periostitis (?) lower end of femur. 7—Abscess of perinæum. 9—Bruise of groin and scrotum. 11—Pen in foot. 13—Extravasation of urine. 19—Ostitis of femur. 20—Palmar abscess.

Charity—3—Disease of shoulder-joint. 4—Fractured tibia and fibula. 7—Injury to back—burn. Femoral hernia. 8—Injury to hip 9—Bursa patellæ 13—Disease of ankle-joint. 18—Burn—hip disease 19—Phlebitis of right leg 25—Scald of throat—tracheotomy

Answers to Correspondents.—Mr. R. J. Pye-Smith—The age of the patient whose history was given in our last was 24, and the date of admission February 17th.

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Physician to, and Lecturer on Medicine at, Guy's Hospital; and

WALTER MOXON, M.D., F.R.C.P.,

Physician to, and late Lecturer on Pathology at, Guy's Hospital.

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THERE is one operation which we have not often the opportunity of seeing in the theatre, and indeed which is not frequently performed at this Hospital, except by one of our surgeons.

Yet it is of great interest, and in that respect is at least as attractive as its rival. We refer to Lithotrity. It has been performed twice lately by Mr. FORSTER, and these two cases show very well what may occur as its results; they are recorded in another column. The first seemed as likely to be suitable for the operation as any, but on account of the outer coating of the stone being of a softer material than the central mass, the impracticability of crushing was not discovered till this had been attempted. The result of the attempt was somewhat alarming; instead of the usual sudden crack of the stone which so clearly tells what has taken place at the hidden end of the instrument, the screw worked for a short time apparently with the effect of burying the blades in the stone, but then came a dead lock. No force would further approximate the blades, the screw was therefore reversed, and the lithotrite opened. An attempt was then made to close the instrument prior to its removal from the bladder, but this was resisted. It seemed as if the blades had become so buried in the softer exterior as to fix the stone upon one of the blades and prevent its dropping from its grasp. This was indeed alarming. It was a sufficient disappointment to find that the stone could not be removed by the lithotrite, but needed the (in point of risk) major operation, but to perform lithotomy without a grooved staff and with a lithotrite in the bladder, the stone being fixed in its blades, was an unpleasant anticipation indeed. Upon manipulation of the lithotrite Mr. FORSTER found that, whether he was still grasping the original stone in the blades or not, there was a calculus free in the bladder. Now, happily the problem was solved by finding that, although by the pressure of the hand, the lithotrite would not close, yet by the use of the screw its blades approximated; it was then withdrawn. It was found that the female blade had become bent to such an extent that while the little power exercised in sliding the blades with the hand was insufficient to restore it to its original shape, this could be done by the screw. The subsequent operation of lithotomy unfortunately proved fatal; the calculus was composed of oxalate, coated with phosphates.

The second case, also recorded in another column, was a successful one, the stone being easily seized and crushed, and that with great rapidity,

We have seen this operation so very successful in several cases in removing large stones from patients who would most probably have sunk from being cut, that we cannot help thinking that by its more universal use much adult life might be saved that is sacrificed to the knife. Although "cutting" is generally much to be preferred in children, yet we cannot help recalling a remark that Mr. FORSTER has made. He says that when the stone in a child is known to be small, and about the size of a coffee-berry, as it often is, the risk which is necessarily incurred in making an incision is scarcely justifiable, since it can be so easily removed by a small lithotrite.

We can hardly wish, however, to see lithotrity performed by means of any of the instruments at present provided for the purpose by the Hospital. By these, what is an exquisitely neat and dexterous operation is converted into a clumsy and even dangerous one. Not being provided with any means whereby the full power of the hand can be brought to bear on the stone, it becomes necessary to employ mechanical violence to make these instruments effective. On the other hand, Weiss and Thompson's instruments are handy, and are constructed so as to communicate almost any degree of force from the hand to the stone, rendering the operation different, not only in character, but also in risks.

Clinical Lecture.

ON ACUTE PNEUMONIA.

By Dr. Moxon.

(*Concluded,*)

The several causes of death in pneumonia are—

1. Febrile action.
2. Typhoid adynamia.
3. Cerebral exhaustion.
4. Simple asthenia.

The first is not a frequent cause of death. Dr. Stokes, in his lecture on Fever, says, in reference to the question of change of endemic constitution, that the pneumonia is not now so sthenic, and does not produce the firm red hepatization it formerly did. Be this as it may, it is comparatively rare to find the patient die as it were overwhelmed with febrile reaction. It is more ordinary to find the patient exhibit the second condition, and pass into a state of prostration and low delirium with sordid tongue and teeth, in short a generally typhoid state. The man in No. 5 bed died so, and it was worth your notice in explanation of his extremely sunken state, that on the seventh day of his complaint he had walked a long distance to the hospital. Other cases show violent cerebral disturbance, leading to cerebral exhaustion. Thus I inspected the body of a man who, living a recluse life, was found sitting in the fender, and throwing the ashes about his room; it required three men to bring him raving to the hospital. Such cases may pass into coma. They may often be traced to causes of, and tendency to, delirium tremens. You are doubtless aware how frequently pneumonia comes in to terminate chronic nervous diseases, such as ataxia, &c. Some think the pneumogastric innervation is at fault in them. Yet other cases die out in a way that can only be called simple asthenia, as if poisoned by antimony or slowly bled to death. The prostration they show differing from that of the second class of cases in the absence of those signs of blood-change which constitute the typhoid condition.

These several lines of main danger, if I may so speak, are not the only variations we have to notice. No doubt they are partly attributable to other conditions which stanp to them as causes, and some of which are physically recognisable, while others escape our notice as yet altogether.

Thus, besides the sudden shiver, and shock of grave illness, followed at once by very high fever, oppression and pang or great pain in the chest; rapid breathing, flushed cheek, and perhaps hepatic efflorescence and expectoration of rusty sputa, all which constitute the characters of acute pneumonia. You meet with a variable set of symptoms, which are of very great significance to the particular patient, although they are too inconsistent to be reckoned in the pneumonic characters. Such are excessive head symptoms; albuminuria, jaundice, excessive digestive disturbance; dysenteric diarrhœa. Albuminuria is very frequent; jaundice not infrequent. I believe neither of these has been shown to much alter the course of the pneumonia, but that only proves how merely superficial is our view of a change that can include these, while we cannot estimate them. Excessive digestive disturbance is very important; the nutrition of the patient fails at the critical time, and thus his prostration is increased. Obstinate diarrhœa may prove embarrassing in your management of cases of pneumonia, and may fatally exhaust the patient.

Now of all these varieties of course and various dangers the morbid anatomist cannot give much account. He can little explain the albuminuria, less the jaundice and the head symptoms and bowel trouble; and his explanations, such as they are, come after the facts and never could have anticipated them. He can show how the states he sees correspond more or less to the symptoms, but he cannot say how they arose. It is at the bedside we must discern and estimate them.

They may be the expression of starvation and ill-usage. They may be, on the other hand, due to hereditary weakness of the kidney comparable to the tenderness of a fair skin, or to the predisposition to baldness, or they may be the results of all the changes which the course of life has brought upon the organs, such for instance as those which ultimately convert pretty little feet into gnarled and knuckley unshapeliness. This is rendered likely, because these variations in the course of pneumonia increase with age, so that a child's pneumonia is singularly benignant and simple being usually devoid of the accidents I have named, while pneumonia is variable and more beset with risks in the aged and labour-tried. Thus Griesinger says of 33 cases under 30 none died, of 10 between 30 and 40 one died, of 7 between 50 and 60 three died, and of 6 between 60 and 70 three died.

What we want in any case of pneumonia is first to make no mistake about its nature, and second to cure it. In this the fruits of post-mortem examination, valuable as they are, help you little. You must watch and reflect upon the clinical course of each case. Men try to measure the degree of solidification and watch its progress, as if that helped; but it is wholly wrong to exhaust your patient by repeated examination, for even if you could accurately measure the amount of consolidation that would not accurately measure the danger. The degree and kind of danger must be estimated from the clinical symptoms such as I have mentioned. Give the best pathologist in London the lung from an acute pneumonic case such as ours, and he cannot tell you what varieties of symptoms were suffered, and what death was died. Yet it is to these more individual peculiarities of the case your treatment has to be directed. You have to treat the individual. The poor creature who

came in and lived only a few hours, having indeed a pulse of 160 on admission, and being pale and sinking, though rather actively delirous, showed a combination of simple asthenia with nervous exhaustion. So like death by bleeding, by antimony, or by digitalis, that I for one am most thankful I used no such practice upon her. Pray see how plain is the teaching of such a case. To give antimony or to bleed at all in the course of it would surely have been horrible, when you saw that she died as if by such means, yet perhaps in her case there may earlier have been a great temptation to do it. In viewing the high action of acute pneumonia, pray remember that before death it may become this thing that you witnessed, and reflect whether any violent means would suit the future of your case. The chief acquirements are that you should see to there being a temperature of 63 deg. evenly present in the room, and good nourishment, and then a cautious and judicious, not "heroic," use of remedies suitable to the particular kind of symptoms that prevail in this really very variable disease.

NOTES ON HISTOLOGY.

(From Dr. Pye-Smith's Demonstrations of Practical Physiology.)

(Continued from page 205.)

Connective Tissues.—The second group of tissues consists of those which beside *cells* are made up of *intercellular substance* or *matrix*, probably in all cases an excretion from the cells which lie in it, and comparable to the cellulose capsule formed around vegetable cells, and to the "cement" which connects epithelial capsules and is stained by the action of silver. The tissues thus defined form a natural group, all derived from the middle layer (mesoblast) of the embryo and capable of physiological and pathological substitution.

Hyaline or Alveolar Cartilage.—Embryonic cartilage, as seen in the notochord, consists of round nucleated cells packed together. After a time they are found in the future bones, as in permament articular cartilage, separated by a transparent glassy (*hyaline*), or faintly granular, structureless matrix. The cavities in which the cells lie, singly or in groups of two or three, are called *loculi* or *alveoli*. The cells are large, oval, bright, with a distinct large nucleus and one or more nucleoli.

Ex.—Costal cartilages. Cut sections: add acetic acid: stain with carmine. Near the surface notice that the cells are smaller, less rounded, and arranged in layers. In many specimens the intercellular matrix will be found more or less fibrous, and, in specimens from old subjects, granular and opaque from calcareous deposit.

White fibro-cartilage. Cells less abundant. Matrix of parallel wavy fibres. *Ex.* Intercostal disks. In sections notice that outside the cells are few and the matrix strongly fibrous, while in the centre the matrix is scanty, soft, and structureless, and the cells numerous—a near approach to the embryonic condition of the disk as part of the notochord. Treat sections as before.

Yellow, elastic or *reticular fibro-cartilage.* Cells as before. Matrix composed of a dense network of interlacing fibres. *Ex.* Ear. Notice the slight effect of acetic acid on sections. Mount in glycerine.

White fibrous tissue. Cells few, small, fusiform, or represented only by their oval nuclei. Matrix, wavy bundles of very fine, colourless, parallel fibres, rendered transparent by acetic acid. *Ex.* Tendon, ligament, fascia: sclerotic where the fibres are densely felted together. Tear up with needles: add acetic acid, and stain with iodine or carmine. Transverse section of dried tendon under low power.

Young cells seen of round form, *e.g.*, in fibrous tissue of omentum of fœtus, free from fat; stellate and fusiform, *e.g.*, in connective tissue of pregnant uterus; oblong with large nuclei, *e.g.*, in tendon of tail of young rat, stained with gold.

Yellow or *elastic fibrous tissue.* No cells. Fibres broad, bright, curling, not parallel, with sharp-cut ends, having somewhat the same relative appearance to white fibres as silk bears to fine linen. Rendered plainer instead of dimmer by acetic acid. *Ex.* Ligamentum nuchæ of ox, lig. subflava of man. Tear up.

Areolar tissue. Soft connective tissue made up of varying proportions of white and yellow fibres. *Ex.* Intermuscular septa and perimysium from beef, and fresh in frog: the latter in salt solution.

Gelatinous or *vitreous tissue.* Œdematous connective, with round cells and very faint fibrous matrix. *Ex.* Vitreous of ox. Shade the field of the microscope and drain off the water on blotting paper after cutting a piece with sharp scissors. The same is seen in Wharton's jelly of the umbilical cord, and in the œdematous subcutaneous tissue of a fœtus which has died dropsical before fat has been deposited or after it has been absorbed.

Retiform connective tissue. The variety found in the spleen, lymph glands, and other "adenoid" organs.

Neuroglia. That found in the brain, cord, and retina.

Adipose tissue or fat is areolar tissue with oil-holding cells. Notice their large size, rounded shape, sharp outline and absence of nucleus. Break them, and see the oil-drops which escape and the shrivelled cell-wall: the nucleus may then be sometimes brought into view, by help of acetic acid or staining. In some specimens radiate crystals of margarin will be seen. *Ex.* Subcutaneous fascia: sub-conjunctival tissue of ox: fresh omentum of cat.

Marrow. Yellow (*e.g.*, from the shaft of an ox-bone) is simply adipose tissue with very little of areolar fibres, the cells being usually rather small and squeezed into more or less regularly angular forms.

Red marrow, from cancellous tissue, is seen to consist of much smaller nucleated oval cells, like leucocytes, with very vascular connective.

Bone. Cells small, oval, with the nucleus attached to the cell-wall, and with numerous candate processes, which unite one cell to another. Matrix hyaline or granular. Owing to the hardness of the matrix, the blood-vessels run in definite channels called *Haversian canals*, and the cells group themselves in concentric circles around these, forming *Haversian systems.* (Analogy to towns grouped around rivers.) Hence there will be *inter-Haversian gaps*, receiving plasma from more than one vessel, *layers* instead of circles of cells, where they are close to the vascular periosteum or medullary membrane; and an entire *absence* of Haversian systems and canals in thin pieces of bone, as cancellous tissue, crusta petrosa of tooth and the humerus of a frog. The alveoli or loculi of the bone-corpuscles are known as *lacunæ*, those in which their stellate processes lie as *canaliculi.* Bone softened in acid: cut longitudinal and transverse sections. Stain with iodine. Compare with ground-down sections. Tear to pieces a decalified section which has been boiled in solution of soda.

Cut sections of ossifying fœtal bones which have been macerated in chromic acid.

Tooth.—Beside the *pulp*, which is vascular connective tissue, a tooth consists of three parts:—

(1.) *Crusta petrosa* or *cement*, bone without haversian systems. (2.) *Dentine* or *ivory*, consisting of (*a*) wavy, branching tubules which radiate from the pulp-cavity outwards, and are really canaliculi which contain protoplasmic processes of the cells of the pulp; and (*b*) the intertubular hyaline matrix like that of bone. (3.) *Enamel*, consisting of hexagonal rods, fixed together with no intervening matrix, and placed so as to radiate from the surface of the *dentine* to that of the tooth.

Cut sections of softened teeth, horizontal and tangential, to see the tubules in longitudinal, oblique and transverse section. Compare with ground-down specimens, on which the structure of the enamel must be studied.

TABLE OF THE CHARACTERS OF THE CHIEF VARIETIES OF CONNECTIVE TISSUE.

	Cells.	*Matrix.*	*Chemical Comp.*
1 WHITE FIBROUS TISSUE	fusiform, &c.	wavy fibres	gelatin
2 YELLOW DITTO	absent	nuclear fibres	elastin
3 AREOLAR DITTO	as in 1	1 and 2	1 and 2
4 ADIPOSE DITTO	large, round	3	margarin and olein
5 VITREOUS DITTO	round or fusiform	1 (œdematous)	mucin
6 HYALINE CARTILAGE	large, oval	hyaline	chondrin
7 WHITE FIBRO-CARTILAGE	as in 6	as in 1	ditto
8 YELLOW DITTO	ditto	as in 2	ditto
9 OSSEOUS TISSUE	small, stellate	hyaline	gelatin & earthy salts
10 DENTINE	unicandate	ditto	ditto

ALCOHOL, A DRUG, FOOD, OR POISON.

BY R. E. CARRINGTON.

Being the Prize Essay of the Physical Society.

The subject of Alcohol is one that, approach it in whatever direction one may, is fraught with difficulty, and yet it is one of surpassing interest to the medical practitioner. A mind perfectly unbiassed turning to the subject, is soon bewildered by the amount and conflicting character of the evidence set before him, and this, too, supported by the names of those most to be held in respect. The true nature of alcohol involves the observations of the chemist, equally with the physiologist; and when one of the most distinguished observers of the day states that he was occupied three years, simply in determining only one of the properties of this substance, the medical student may well pause before he suddenly comes to any fixed determination upon this subject. Our knowledge is truly in a transitory state with regard to Alcohol, but it has been my poor endeavour, to the best of my ability, to weigh the facts of the case together, and try to draw from them some conclusions that may probably be of practical use.

It will be convenient, at the onset, in considering whether Alcohol be a food, to determine what we mean by such a substance. There is some little difficulty in giving a definition of a nutriment, founded on the fact there are some substances which are essential for the well-being of the vital economy; which pass through the system without in any respect altering in composition. But, I think, if we say, that a food is a substance which is capable in some way of maintaining the composition of the organism, or of ministering to one or other of the vital processes, we shall include all bodies which can be rightly denoted as such. If we were to say that a food is a substance which, by its injestion, and subsequent absorption, quickens the heart, increases the amount of carbonic acid expired, and raise the animal temperature, we should probably be saying what is nearly true of everything known as such, in common parlance. Alcohol is a substance consisting of carbon, oxygen, and hydrogen, and of these only. It contains no nitrogen, and, therefore I think, we may dismiss at once the idea that it can be instrumental in building up any tissue containing that element; but there is one substance in the economy to the formation of which its chemical constitution would be no hindrance, and this substance plays a varied and important part in the animal organism. Can alcohol form fat? Some might, no doubt, at first sight be apt to answer this question offhand in the affirmative, for we do see persons who are large consumers of alcoholic drinks get very fat, but this is by no means the universal rule. One finds that the character of the liquor has a vast deal to do with it. It is true that beer-drinkers often do lay on large quantities of adipose tissue; but if we take the case of one who habitually ingests excessive quantities of ardent spirits, and notably of gin, what a miserable, wretched-looking, emaciated individual do we not see? Alcohol is, without a doubt, a prime agent in the production of fatty degeneration, and especially with regard to the heart. If this were universal, it would probably be much to the point. It is a qusstion whether the fatty change is actually a degeneration of muscular tissue with formation of fat, or simply a deposition of this substance in the tissues. I have seen both views stated. Dr. Richardson says "The muscles, including the heart, become the centres of degeneration called 'fatty,' and by the interposition of cells of fat in the minute muscular elements the activity of the fabric is destroyed;" whilst in the pathology of Drs. Wilks and Moxon, we are taught that the condition produced is rather "obesity," or an excessive deposit of fat upon the surface, and encroachment of adipose tissue between the fibres which may, by its pressure, cause atrophy of the fibre: the fat growing in the direction of the vessels. This is especially seen in those making excessive use of malt liquors. But allowing this to be true, surely this is the wrong sort of fat, and if the sequence of cause and effect were perfect, its occurrence ought to be far more universal than it is; and what seems to me to vitiate the argument of cause and effect greatly, is that such a fatty degeneration of the heart is often associated with a condition described as "greasy leanness." Alcohol may indirectly promote the formation of fat by inducing desire for sleep, or physical repose, and producing tardiness of, and disinclination for, muscular movement; but a mode in which it may also have this effect, is so mixed up with the subject of its decomposition within the body, that it will be convenient to consider this point with it. Dr. Carpenter, as the result of his enquiries, is led to believe that Alcohol, by direct chemical re-composition, does not produce fat, and if we consider that there is no universal rule that a large ingestor of Alcohol increases his adipose tissue, but on the contrary, that a person in the habit of consuming gin (a liquid consisting almost entirely of alcohol and water) becomes

emaciated; I think it may be inferred that we not only have insufficient evidence to prove this point, but rather that what evidence we have points the other way. But there is yet another class of food which is of equal importance with histogenetic or tissue-forming nutriment, comprising a number of bodies, which, by their actual decomposition, are able to maintain the animal heat. From these even I think it may be said that Alcohol differs in this respect—that though they may be only calorificient, yet they are likewise capable of tissue-formation. These bodies, which contain no nitrogen, are characterised by the property of decomposing into carbonic acid, and water, in their passage through the system; and by this means furnishing heat directly. Whether we can include Alcohol in this sense is a question about which very much has been said. Dr. Carpenter says that it was only in the case of excessive doses of Alcohol they escaped oxidation. He believes that Alcohol is a subatance eminently susceptible of this process; and we know how easy a matter it is to oxidate this substance; how, if a piece of porous paper be moistened with it, and then sprinkled with platinum black, the heat of combustion is soon great enough to cause ignition, and if one were to reason the matter out, I think would come to the conclusion that if Alcohol were subjected to the conditions to which it is when circulating in the blood of the living body, what an enormous surface of it is exposed to oxygen which must be in a peculiarly active condition, frem the ready manner with which even such a subject as sugar is disposed of; we should, I say, if we were not under the guidance of experimental research, at once conclude that Alcohol ought certainly to be burnt off, and if it were not that there must be some special provision to prevent it. At all events this is what was generally believed until three notable observers—MM. Lallemand, Duroy, and Perrin, by numerous experiments satisfied themselves—that after ingestion of Alcohol, this substance passed off at once by the various excretory channels—lungs, skin, urine, and fæces, and that this process continued for many hours. They were also unable to detect any of the products of the oxidation of Alcohol such as acetic or oxalic acids. M. Subbotin performed some experiments on rabbits enclosed in a chamber, through which the air was slowly drawn. In eleven hours he found 12·6 per cent. of the alcohol ingested eliminated, and in twenty-four hours 16 per cent., and in his observation he found the excretion to extend over twenty-four hours. Dr. Edward Smith repeated and varied the French experiments, and was convinced of the truth of the results, and I suppose that such elimination does take place cannot be for one moment doubted. We are all aware of the alcoholic breath of the person who has been indulging in some sort of liquor, and what is much more to the point is that we find in observations made by Dr. Anstie, that Alcohol can readily be detected in the urine, breath, and cutaneous inhalations very soon after their ingestion; but that this substance can be detected in the excretions is allowed at all hands. The difficulty is this: it has never yet been possible to recover all the Alcohol that has been ingested. Much of the doubt in this respect must be in the imperfect means of estimating Alcohol. The test chiefly used is that with bichromate of potash and sulphuric acid. This depends mainly on alteration of colour, and one can readily see how, in quantitative estimation, too much reliance cannot be placed upon its indications. It has, however, been improved upon by Dr. Dupré, of the Westminster Hospital, and he estimates the amount of acetic acid formed by the oxidation of the Alcohol, by means of a standard solution of soda. A remarkable fact was brought out in his investigation which was this: that the urine of persons not taking Alcohol at all, sometimes contained a substance capable of affecting the test in the same way. This was, however, not universally present even in the same person. The observation has been confirmed by Dr. Parkes and Professor Binz of Bonn, so that one sees sources of fallacy on all hands. The matter stands pretty much as it is represented by two eminent observers who have embraced different views of the question. Dr. Edward Smith says that after ingestion of a given quantity of Alcohol this substance is capable of detection very speedily in all the excretions of the body, and notably the urine, and this will be the case for many hours. Of course it would be in the highest degree desirable that all the products of excretion should be collected until the Alcohol were entirely recovered. He has done this for thirty-six hours but says it is well nigh impossible to do so for a longer time. He lays great stress upon the fact that even after forty-eight hours Alcohol totally unchanged is discoverable in all the tissues, and this is a fact that was observed by Dr. Percy; and since his time by many others, and is one not contradicted. This being the case then he says it is scarcely reasonable to ask for so much proof. Given these two facts have we not at all events proof presumptive that the Alcohol is not changed? It has been objected to the experiments of MM. Lallemand, Duroy, and Perrin, that they always used their Alcohol in intoxicating doses; and this fact will, I think, gtve us a possibility of reconciling the two opposite views. Dr. Anstie, who was assisted in his observations by Dr. Dupré, an eminent chemist, has made many experiments upon the subject, and the latter has also instituted observations of his own; but as their final results were identical I may make Dr. Anstie speak for both. He took up the position of M. Bandot, who thought if Alcohol is totally eliminated as such, a sensible result ought to be obtained in the urine collected for twenty-four hours after its ingestion. Such, however, never was the case and the result of testing with the alcometer was absolutely *nil*. He always, however, got very appreciable results with the chromic acid test, and calculating that he was always able to detect one centigramme of Alcohol per litre (.155 grs. to the quart), and taking the quantity of urine in twenty-four hours at the utmost at two-and-half litres; he concluded the amount of Alcohol passed at such must be very small indeed. Dr. Anstie followed the matter still further, and using a test solution of one part of the bichromate of potash to 300 of pure sulphuric acid, he found that he could get a decided re-action with $\frac{1}{50}$ of a grain of Alcohol; and also with an aquaous solution of two grains and a fraction to the ounce, and I find that with such a solution a mixture of spirit and water, which gives the faintest possible odour and no taste, will re-act most decidedly. He made numerous experiments, the result being to show that when Alcohol is administered in doses that were full, but not excessive, that very little of it was eliminated in the urinary excretion. In the first of these observations; a pint of light beer containing 3 per cent. Alcohol was administered at one p.m. to a man aged thirty. The first urine was collected at 5.10 p,m., and was tested by placing it in a receptacle communicating with the U tube containing a known amount of his standard chromic acid test. A strong current of air was then passed over the urine, and through the test solution. After two hours the development

of a green colour became stationary, and he found that taking an equal quantity of the chromic solution, and dropping into it 30 minims of a mixture of Alcohol, and water (1—249), that a much higher colour was produced. No other urine passed affected the test: and the ingestion of 2 oz. of sherry by the same man produced even a smaller result. He also made observations on the pulmonary exhalation; and administered half-pint of Bass's ale to a healthy man. Expiration through the test solution was commenced four minutes after, and at the close of 85 minutes it was found that a dark emerald colour had been produced; and that expiration through a fresh portion of test liquid had no effect; but an equal depth of colour in an equal amount of test solution was produced by five minims of absolute Alcohol. Examination of the urine produced as little result as in the preceding observations. Examination of the cutaneous transpiration was not undertaken; but during the experiments from external conditions, these were at a minimum, for both the weather, and room were very cold, and when such notable channels of excretions as the lungs, and kidneys shewed such a small result, one would certainly not expect the skin to have a greater action. This is not a mere matter of conjecture, for all observers allow the excretion by the skin to be small. Some final experiments of Anstie's (which are recorded in the "Practitioner" for July 1874), put the matter, if possible, in a stronger light. The observations were made on dogs which were shut up in an air-tight chamber, and the products of execretion in every mode collected. In one dog which weighed 10lbs., ℥ ij. of brandy containing 47·73 grainsof absolute Alcohol were administered, of theseonly $\frac{1}{5}$ of grain were eliminated by every channel. In another dog weighing 9 lbs., 12 ozs., nearly 2000 grains of absolute Alcohol were taken in 10 days, and on the last day only 1·13 grains of Alcohol were eliminated; and out of 98·1 grains given, only 23·66 grains were recoverable, notwithstanding every precaution to prevent loss. Dr. Anstie, with, it seems to me, justice, remarks that the fact of the presence of unchanged Alcohol in the tissus for so long a time as forty-eight hours, has not really so much importance as has been attributed; for there is no reason why, after all that is capable of elimination has been thrown off, a certain amount should not remain and undergo a slow change. Certainly, MM. Lallemand and Perrin did not continue their observations long enough to disprove this. Does he not, then, with justice say, that when a certain amount of Alcohol is given to an animal, if none were disposed of in the system a large amount at all events ought to be recoverable, yet he never obtained more than a fractional part of the whole quantity taken? Corresponding observations were made at the same time by Schulmes, and his results were in accordance. Dr. Parkes was so much impressed with the accuracy of the experiments, that he says "it seems quite certain that when the amount of Alcohol does not exceed 1½ fluid ounces of absolute Alcohol, and especially if taken in divided doses, the amount which passes off in the kidneys is exceedingly small," and he goes on to say; that any large dose which produces signs of narcosis immediately causes unaltered Alcohol to be eliminated by the kidneys, and that conversely alcoholic urine is a sign of narcosis. His obversations confirmed the above result, and he found, that with too powerful men the quantity capable of decomposition in twenty-four hours was something between one and two ounces, and he thinks he is rather above, than below the mark when he says 1½ ounces. As far, then, as one is able to form an opinion, I am inclined to think the results will vary considerably with the amount of the dose; and whether it is administered at once, or in successive equal quantities. There is no doubt that there is a large disappearance of Alcohol somewhere, and this is especially noticed when the dose is small.

(*To be continued.*)

Operations.

Friday, April 2.

Mr. Cooper Forster performed lithotomy on a man, æt. 30. He had attempted lithotrity on this man, and having caught the stone the lithotrite bent, and was after some difficulty extracted. The stone was an inch and a half in long diameter, and an inch in the short. The crust was broken in part from previous crushing. The stone consisted of an oxalic acid nucleus, with concentric rings of oxalic and lithic acids, and was very hard. The man died on the 6th.

He afterwards peformed lithotrity in the ward on a man, æt. 59, crushing tha stone six times in a minute. This patient has now been operated on thirteen times.

Monday, April 5.

Mr. Birkett removed a tumour from the breast of an unmarried woman, æt. 25. She had noticed it only nine months, but during that time it had doubled itself in size; it projected from the outer side of the breast; was freely moveable under the skin, but seemed to have a certain connection with the gland itself, thus suggesting that it partook rather of the nature of a lobular hypertrophy than of an encapsuled adenoid growth. The veins over it were much enlarged. She had been under Mr. Birkett's care for three months previously, but he thought it not advisable to interfere with it at that time. As, however, it had grown considerably since then and caused the patient a great deal of pain, he now felt justified in operating. An incision was made on the outer surface of the breast, and the tumour which was encapsuled easily turned out. On examination it proved to be a perfect specimen of mammary gland tissue.

Tuesday, April 6.

A female, aged about 40, having a large right inguinal hernia, with some symptoms of strangulation, was placed on the table to be operated on by Mr Bryant if, it were found to be necessary, but when under chloroform the hernia returned even without taxis.

Mr. Bryant then proceeded to perform a plastic operation for the closure of a fistulous opening in the urethra at the lower part of the penis, said to have been caused by catheterism. A portion of the skin was raised up from one side, the dissection being made away from the urethra, on the other side a smaller flap of skin was made, the dissection being towards the urethra. The second flap was then turned over so as to close the fistulous opening, and stitched to the opposite side beneath the first flap of skin. The first or larger flap was then replaced, bringing it over the smaller flap, and stitched to the adjacent integument by

means of fine catgut sutures, and the part dressed with lint soaked in the compound tincture of benzoin. In this operation the cuticular surface of the smaller flap formed the floor of the urethra, while the raw surfaces of the two flaps were in contact.

The next operation was for necrosis, the result of acute periostitis. There were two sinuses leading down to dead bone, one at the upper and the other at the lower part of the humerus. Mr. Bryant cut down on the bone at both these points, and from the upper removed the necrosed portion of the shaft. The dead bone not being loose at the lower part was left for a subsequent operation.

Correspondence.

[We do not hold ourselves responsible for the opinions expressed by our Correspondents]

To the Editor.

Sir,—The traditions of our hospital are dear to every Guy's man. How, then, was I distressed (in common, I hope, with many more) to see a new title introduced in your last number to the exclusion of one which carries with it probably more distinctive and pleasant memories than that of any other appointment. I am aware that the abbreviation "ex-Dresser" has been persistently misunderstood by some (who do not profess to be surgical), but when the title is given in full I do not know why "Late Dresser for the week" is to be preferred to the now classical title, "ex-Dresser for the week"; and certainly it jars distressingly on the sentimentality of

Yours, &c.,
An Old "ex-Dresser."

April 7, 1875.

[Our correspondent will see, from the present number, that it is not our intention to continue the altered appellation to which he so justly objects; but the change was rendered necessary last week, for, owing to the change of dressers on the 1st of April, the "*late* Dresser-for-the-Week" did not hold the position of "*ex*-Dresser," being succeeded by Mr. Coley,—Ed. *G. H. G.*]

The Surgery.

We have lately had two cases of fracture of the lower end of the radius. In the first the patient, a man, aged 28, fell down a ship's hold, and suffered other injuries in addition to the fracture of the radius, so that he had to be admitted into the hospital. The second case was that of a woman, aged 47, who fell upon her extended hand. In neither case was the characteristic displacement very plainly marked, and in both the bones were easily got into good position. Both cases were put up on a long *straight* anterior splint, with a shorter posterior one.

Two cases of partial or green-stick fracture have been treated; both occurred in children under six years old. In one case the clavicle, in the other case the radius, was the bone affected.

ROYAL COLLEGE OF SURGEONS.

The following Guy's men were successful at the Anatomical and Physiological Examination for the diploma of Member:—

April 6th—Messrs. Berry and H. Davy.

April 7th—Messrs. Horrocks, Meek, and Uhthoff.

The paper will be given in our next number.

The Wards.

The following Cases were admitted between April 1 and April 8

MEDICAL.

Addison.—3—Chorea 4—Ovariotomy 6—Sub-acute rheumatism 13—Phthisis 15—Asthma.

Philip.—3—Sclerosis 6—Spinal curvature—ascites—paracentesis abdominis 9—Locomotor ataxy 13—Ague 17—Stricture of urethra 21—Enterica—bronchitis. 35—Rheumatism 36—Morbus cordis 42—Bronchitis 48—Pneumonia—delirium tremens—death.

Bright.—6—Bronchitis 10—Cirrhosis—ascites 19—Mitral stenosis. 20—Chorea 21—Aortic constriction.

Miriam.—17—Chorea 21—Mitral stenosis 23—Pneumonia 26—Ague—phthisis 32—Pneumonia.

John.—1—Acute rheumatism—morbus cordis 2—Hæmaturia 3—Epilepsy—alcoholic poisoning 8—Phthisis 12—Mitral stenosis 14—Phthisis 15—Morbus Addisonii.

Mary.—13—Incipient phthisis 16—Chronic arthritis.

Stephen.—12—Epilepsy 20—Phthisis 24—Albuminuria 26—Rheumatism 30—Sarcoma (?) of leg 31—Lumbago 36—Phthisis 42—Morbus cordis 48—Acute rheumatism—pericarditis.

SURGICAL.

Dresser for the week, Mr. Burton.

Ex-Dresser, Mr. W. Cock.

Cornelius.—19—Fractured tibia and fibula

Lazarus.—9—Ulcer on leg 13—Ulcer in rectum. 18—Necrosis of superior maxilla. 22—Epulis

Job.—6—Chronic synovitis of knee. 12—Synovitis of knee

Luke—10—Old burn on ankle 12—Ulcer of leg 16—Ulcer of leg 18—Calculus vesicæ 20—Palmar abscess—amputation

Naaman.—2—Bursa 9—Stricture 11—Necrosis of tibia

Dorcas.—3—Necrosis of os calcis 9—Morbus coxæ 14—Psoas abscess 26 (cot)—Morbus coxæ

Lydia.—5—Strangulated femoral hernia 7—Chronic synovitis 29 Morbus coxæ

Mr. John Rees has passed the examination for the Royal College of Physicians, Edinburgh.

Appointment.—William Arthur Brailey, M.D. Cantab., M.R.C.S., L.S.A., Fellow of Downing College, Cambridge, and formerly a student of this hospital, has been appointed Lecturer on Comparative Anatomy at St. George's Hospital Medical School

Received.—The London Medical Record, The Sanitary Record, The Report of the Medical Officer of Health, Portsmouth.

The Presidents of the Physical Society respectfully acknowledge the receipt of Honorary Subscriptions from Dr. Savage, £1 1s., N. Davies-Colley, Esq., £1 1s., J. Towne, Esq., £1 1s

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Guy's Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—No. 28. SATURDAY, APRIL 17, 1875. TWOPENCE

WE publish to-day the names of the remaining successful candidates at the recent First College Examination, making a total of seventeen men, and we feel much pride in stating that *not a single man was referred.* This is unprecedented success, and speaks well for the men, and well for the teachers, and they must feel rewarded for their hard work. We look with confidence to the second batch to maintain this brilliant result, and trust that they will pull themselves together for the struggle in the time that still remains.

Although it may with truth be said the number was small, and consisted of just the pick of the men, yet we think there are many who might have been signed up had they desired, but feeling perhaps weak in one or two points, preferred to wait for three weeks. This is all to their credit, as it shows that they wish to maintain a good average, and are averse to trusting those one or two points to "luck."

That much is left to "luck" by some men at the First College, we feel sure, and are sorry for it; for though they succeed in passing, yet sooner or later they will regret the mis-spent time in the Dissecting Room. The examination is called by some unfair because some men pass by getting examined on the little they do know, having left *unread* a great deal; whereas others, who know a great deal, and are much better up than the former, fail by getting examined on one or two things of which they are totally ignorant. There is indeed here a piece of luck for the former; but had both gone over all the ground carefully, they both would have been pretty certain of passing, whereas in the present cases both were uncertain.

We have spoken previously in these columns of the examination itself, yet there are one or two points which we would like to mention.

The *viva voce* is short, and hence the number of questions is limited, These are straightforward, and require a like reply; if a man hesitates, or blunders, or gives evasive answers, there is no time to wait, the result is counted against him and another question is put. The time is too short for a man to be taken all over the body, hence his merits must rest perhaps upon his knowledge of a particular region or bone, and what if he does not know it. It is this that makes the difficulty in the First College, and this is why men who do not know one particular thing, though apparently "well up" are referred. We can assure those about to present themselves, that if they have faithfully gone over all the ground, it is impossible to get a question of which they could be totally ignorant, for the Examiners never ask out-of-the-way questions.

While we rejoice over our recent success, we must warn those "going up," against thinking that the examination is becoming easier; this assuredly is not the case and yet some might build a hope upon such a foundation.

We wish every success to the second batch, and ask them to remember that all Guy's men are anxious about the result, and that much of the success of the school depends upon our average at the First College.

A STUDENT'S NOTES OF

Lectures on Midwifery

By J. Braxton Hicks, M.D., F.R.S.
Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

Lecture XXI.

Tumours in the Soft Parts.—I have now given you an outline of the difficulties most likely to be met in labour on account of the state of the soft parts. There are some yet to be mentioned dependent on Tumours. These do not often trouble you, but you must know how to meet them when they do present themselves. The most common one you will see is the fibroma, or fibroid tumour of the uterus. As you know these are found in various parts of the organ; and the value of the trouble they cause depends both on position and size. Size being equal we may say that the nearer they are to the os, the more impediment and trouble they cause. When near the fundus their influence acts so as to render the contraction of the uterus less effective; they tend to cause unequal strain upon the uterine tissue, and thus favour rupture as I have already pointed out; and after the child has escaped they for the same reason prevent the detachment and expulsion of the placenta; and when the placenta is delivered they interfere with perfect uterine contraction, and this, I have already told you, facilitates hæmorrhage, and indeed in all these cases we ought to fully be prepared for such an occurrence. However much we may fear trouble from fibroid tumours, sometimes we are agreeably surprised at the simplicity of all the stages with very great ones. Having detected one very large one at the right side of the uterus in a primapara, I recommended her to come to town to be delivered, as she was awkwardly placed in the country; this she did, she was placed under a medical man, myself being in readiness to attend if trouble arose. I was pleased to hear from him that labour was short and safe, and she recovered very well. I think the more they are extruded to the exterior they less trouble they cause. I remember, on the contrary, one which necessitated turning. I was called in, and arrived as the operation was on the point of completion. No sooner was the placenta away than sudden collapse occurred, and the patient died in a few minutes. No hæmorrhage occurred, and it was clear there was no rupture. It was a case of shock; and this is a state which has not infrequently occurred before. It has been suggested that the contusion the nerves in the uterine tissue receive is the cause. When they are small, well external and above the middle you need not be anxious. When below this point they begin to be obstructive, They grow with the growth of the womb. Consequently the obstruction they will cause in labour will be greater than when we detect them some time before. Once I had to perform Cæsarian section, the consequence of a large one which had grown out laterally from the middle of the uterus so as to fill up the pelvic brim, to which it became attached. Only the arm of the seven months' fœtus could pass the os. Besides this lateral tumour there were others, and these interfered with the closure of the wound and the sinuses, that I had the greatest difficulty in arresting the bleeding from the enormous sinuses. In another case I had to induce premature labour at seven and a half months, and as they occurred very low down I had the greatest difficulty in passing even the sound through the tortuous canal. I then introduced a tent, and in about ten hours I was able to use the dilating bags (of which I shall make more special mention when I come to the induction of premature labour). The child presented footling, but the timely descent of the head was prevented by the tumours, and thus its life was lost. But the mother did well. Sometimes, however, the recovery is not satisfactory, the condition you will plainly see favours the presence of clots and discharges which decompose and infect the patient with septic matter, setting up one of the kinds of puerperal fever. In another case I found a tumour in the anterior portion of os cervix and lower body of uterus obstructing the brim nearly entirely. It was impossible to turn, it was also impossible to employ instruments, and Cæsarian section seemed the only alternative. However, remembering that tumours in this region, especially when, as this one was, they were elastic, were readily ennucleated, I divided through the mucous membrane on its posterior aspect as high as I could reach down to this lower part margin. I was delighted to find my surmise was right, I passed my hand within the capsule drew out with some difficulty the tumour as large as a fœtal head, though not so large; and immediately the head came down and was born in a few minutes. The patient recovered without a bad symptom, and was at my house in a month when I examined her and found her so natural as to the parts concerned, that I could detect no sign of the occurrence.

Tho treatment applicable to labour, complicated with these tumours cannot be laid down in any definite rules. So much depends on their position and size. When the expulsion of the child is impeded by one, of course some means of traction must be used. If there is room for the head the forceps are indicated, but if it is impossible for the head to pass, we shall be obliged to perforate, unless we find that it is also impossible the body can follow, in which case we must have recourse to Cæsarian section. With regard to turning I do not advise it in general; for myself I should avoid it as much as I could, yet even here I would lay down no absolute rule.

Tumours in the vagina or outside are rare, yet they may now and then present themselves. If in the wall of the vagina, a very rare occurrence, they must be treated on the rules already laid down; it is always well, if they are elastic, to pass into them a small trochar and canula in case they contain fluid, which they sometimes do. If outside it is first proper to try if they can be elevated above brim, because it sometimes so happens that an ovary has dropped down into recto-vaginal pouch and the head coming down prevents its recession. To elevate a tumour in this situation you should first of all press up the head, and then immediately transfer the pressure to the tumour. If you cannot do it readily, place the patient under chloroform and then try. If you fail use the trocar and canula. Should no fluid escape, our only treatment is to perforate; at least that is as far as our present knowledge warrants us to go. It has, however, been recommended to cut down upon the ovary through the vaginal wall, draw out the mass, tie the pedicle, divide it and return the stump, and bring the edges of the wound together if possible by sutures. At present we have not sufficient data for me to advise you to follow this, as a rule of practice.

We have had one patient in our Charity, who many times has been under my care, having an elastic tumour occupying half the pelvis, apparently attached to the sacrum. It was wide and flattened in front. In all her

pregnancies we had to induce labour as early as the seventh month. We have never been able to save a child; forceps and turning have been tried, but even then the detention has been a trifle too long. She came to me in great distress one day, because her neighbours had called her an "hermaphrodite." But in her case the elasticity of the tumour increased the projection in front when any attempt was made to draw down the head.

It happened that a fibroma, attached by a pedicle to the exterior to the uterus, like a prolapsus, but of course covered by a layer of peritonæum, has dropped down in front of the head. One such came down in front, and rendered labour very difficult. Of course tapping is of no use. If it were very large so as to cause very much difficulty it would perhaps be wise to perform gastrotomy and draw up the tumour if possible, if not complete delivery by the Cæsarian section.

There is another tumour which now and then obstructs, namely, thrombus of the labia. It is caused by a bursting of one of the veins of the plexus behind the lesser labia, the blood is effused into the cellular tissue, and coagulates. However, sometimes the parts are stretched out so much that the very skin of the labia gives way; you can see the fibres parting from one another, and then fluid blood escapes, sometimes a very large or even a fatal quantity is lost. There is no need of this. The bleeding can always be restrained by laying open the cavity, clearing out the clot, and then plugging by any linen or other material handy. If this does not stop it, clear out the lint, &c., and plug with some fresh dipped in tincture of perchloride of iron; but if there be no opening a compress will often check the swelling. However, we are supposing it to obstruct the progress of the child's head at the vulva, in which case probably all you will want is the forceps carefully applied. If delivery was then difficult, or there were imminent danger of a laceration, I think it the best plan to lay it open, clear out the clot, draw down the head, and then if it were bleeding from the bottom to plug, as I have just now told you. These are not common, however. They occur suddenly, and by that you distinguish them from œdema of the labia, which occurs on both sides.

NOTES ON HISTOLOGY.

(From Dr. Pye-Smith's Demonstrations of Practical Physiology.)

(Continued from page 212.)

The third group of tissues consists of Muscle and Nerve. They only agree in the negative character of not being made of cells, either alone or with an intercellular matrix: although of course they, like the rest of the body, are first formed out of the embryonic cells which result from yelk-cleavage.

Muscle.—The sheath or *fascia propria* consists of ordinary white fibrous tissue, which sends in processes (*septa*) dividing a large muscle into smaller bundles (*fasciculi*). Each fasciculus—and small muscles, like those of of the larynx, may consist of only one—is a bundle of fibres united (or separated) by delicate fibrous tissue called *perimysium*. In this the capillaries form their long oblong meshes, the nerves divide into their ultimate fibres, and here more or less fat is deposited. Like almost all areolar tissue the perimysium is replaced by adipose tissue and *vice versa*, according to the state of nutrition of the body, but the denser fibrous tissue of the external sheath and septa is no more convertible into fat than a tendon or ligament. To see these structures, examine a transverse section of a dried muscle with a low power. The sheath, septa, vessels and perimysium will be seen, with the angular cross sections of the muscular fibres themselves. Next, take fresh muscle of a frog in salt solution, and separate the fibres. They will then appear as very large, soft-looking structures, as broad as the 500th of an inch, and marked by fine, dark, transverse *striæ*. Now put on a high power and the striation will be more distinct, as well as the bright bands between the transverse stripes. Some fibres, however, will show a longitudinal separation into *fibrillæ*, which obscures the striæ; and this will be particularly obvious at the broken end of a fibre.

Next allow a similar torn-up preparation of fresh muscle to soak in distilled water for a few minutes. Under a high power, you will then find that a delicate, glassy, transparent membrane has been raised from the surface of some of the fibres in bullæ, the water having soaked through this structureless muscle-skin or *sarcolemma* by endosmosis In other fibres you will see that an accidental squeeze has broken the soft internal substance and left the sarcolemma as a contracted, rumpled, empty sheath between. At some of the broken ends the sarcolemma will appear twisted out beyond the rest of the fibre, at others the soft muscle-stuff or *sarcous elements* within will be squeezed out by the elasticity of the membrane, much as the meat of a sausage might protrude beyond the gut when cut across.

Examine muscle which has been soaked in dilute nitric acid, or in chromic acid, and you will find on tearing a fragment to pieces that you can break up the fibres themselves. Most often they will divide into the parallel longitudinal fibrils mentioned above, but sometimes into transverse disks, and in a lucky preparation you may see part of a fibril broken across into little oblong pieces, or a disk split into groups of the same. This shows that inside the sarcolemma a muscular fibre consists of minute, soft, oblong, refracting bodies, named sarcous elements by their discoverer, Mr. Bowman, and muscle-prisms by Prof. Kuehne. They are arranged like bricks, set upright and cemented together to form a pillar, so that they may be regarded either as forming rows (*fibrillæ*) united by their sides, or layers (disks) united by their surfaces. And a muscular fibre may be split either into fibrils or into disks, just as a company of soldiers may be marched off by files or by ranks.

Lastly, add acetic acid to fresh muscle, and you will see oval nuclei, set at pretty regular intervals on the inside of the sarcolemma. Several other points in the minute anatomy of muscle are still much disputed, and must be worked out in the living muscle of invertebrate animals with very high powers, and the aid of polarised light.

The muscular fibres of the skin, the mucous membranes and the viscera differ from those just described. They are paler in colour, they interlace, and form layers rather than fusiform masses, and their connective tissue is not distinguishable into a coarser sheath and septa and a finer perimysium. Taking a piece of fresh muscle from a pig's bladder, tearing it up, and examining with a quarter-inch objective, you see that the fibres are narrower than those of a voluntary muscle; they have a soft, grey, gelatinous aspect; you see no sarcolemma, or fibrillæ or disks; and, what is most striking, there is an entire absence of striæ.

The most distinctive positive character of these "unstriped" fibres appears after adding acetic acid: oblong nuclei arranged at regular intervals along each fibre. Each of these rod-shaped nuclei belongs to a fusiform "muscle-cell," and an unstriated fibre consists of a number of these cemented together. By maceration in dilute nitric acid, chromic acid or potash, we can succeed in more or less completely separating these long spindle-shaped cells from each other. A frog's bladder or a fowl's gizzard is a good object to take for the purpose.

Nerve.—A transverse section of a dried nerve under a low power shows a tough fibrous external sheath (resembling that of a muscle, but with more elastic tissue), and septa which pass in from it and divide the trunk into fasciculi (or "funiculi"). Each of these is seen to consist of a multitude of ultimate fibres (seen as minute circles with a black central dot) bound together by an apparently homogeneous connective tissue, the *perineurium*. Tearing up a fresh nerve in salt solution, and using a higher power, this perineurium is found to consist of fine and dense areolar tissue, and each nerve fibre appears as a cord of uniform width. The larger are broader than a white blood-corpuscle, the smaller less than half that of a red one. They are therefore much narrower than a striped muscle-fibre, but broader than even the thick elastic fibres of a bullock's ligamentum nuchæ. When seen in a living animal, the fibre is homogenous and hyaline, or faintly granular: but examined as above, there is seen, outside a strongly-marked waving outline, a fainter boundary, which is the primitive nerve-sheath of Schwann. So far the structure of nerves corresponds with that of muscles. The fibrous sheath with its septa (frequently, but inappropriately, called neurilemma) answers to the same parts in a muscle, the funiculi to the fasciculi, the perineurium to the perimysium, and the structureless sheath of the primitive nerve-fibre (which in modern works receives its appropriate name of *neurilemma*) answers to the sarcolemma of a muscle-fibre. The structures, however, which are contained within this hyaline tube have no resemblance to sarcous elements. Looking to the cut-end of a fibre you will observe a colourless, bright, soft substance oozing out and forming drops in the field. This homogeneous, highly refractive substance it is which by its coagulation shrinks away from the containing tube, and so gives the dark wavy inner outline to the fibre. It is known as *myelin* from a fancied resemblance to marrow, or as the "white substance" of Schwann, its discoverer, and contains protagon and other albuminoid compounds. By soaking fresh nerves in chloroform, or better by putting them up in a drop of collodion, we bring into view the third constituent of a nerve-fibre, its *axis* (or "axis-cylinder" of Purkinjé), a stout solid rod lying in the centre of the tube of neurilemma and separated from it by the myelin. This may be sometimes observed projecting beyond the rest of a cut fibre, and it becomes very plain by staining with carmine. In a transverse section, it appears as the round dot mentioned above, surrounded by myelin, and that again by the circular section of the neurilemma, or primitive sheath of Schwann. Thia axis is the essential part of a nerve-fibre. It is connected at one end with a ganglion-corpuscle and at the other with a second ganglion-cell, or with a muscle, or with some sensory structure. You may imitate a medullary nerve-fibre by filling a thin glass tube with white of egg and running a wire through it; or you may compare the axis-cylinder to a telegraph wire surrounded by gutta percha, and enclosed in a sheath of woven silk.

In all nerves, beside these white, or double-outlined, or medullary fibres, may be found others, which are narrower, averaging about the 5,000th of an inch, and have no myelin. These are known as the fibres of Remak, grey or gelatinous fibres. They are scanty in some nerves (*e.g.*, the optic) but make up the greater part of others, as the olfactory and the so-called sympathetic nerves, and they are abundant in the brain, cord and retina. Moreover every white or opaque fibre when approaching its termination (central or peripheral) loses its myelin and thus becomes a grey or transparent one. To see these, take a piece of the sympathetic cord of a freshly killed animal, and after separating it out in serum, examine with a high power and stain with carmine. Beside the smaller side and absence of a double contour, soaking in dilute acid brings out several oval nuclei which probably belong to the structureless neurilemma. High powers show that the grey fibre itself, like the axis-cylinder of a white fibre to which it corresponds is made up of excessively fine parallel fibrillæ. In the fœtus and in some adult animals none of the nerves have myelin, *i.e.*, the are all "grey."

ALCOHOL, A DRUG, FOOD, OR POISON.

By R. E. Carrington.

Being the Prize Essay of the Physical Society.

With these facts, considering the favourable opportunities for oxidation, and that it is only when admitted in intoxicating doses that any considerable quantity is recoverable, I am inclined to think that the conclusion that such oxidation must take place is a fair one. If we take, then, this as admitted, we are able to explain some phenomena which we noticed when the question of fat formation was under consideration. It is readily seen how the admitted fact—that an excessive beer drinker becomes obese—does so without laying the fat formation to the credit of the alcohol, for beer contains a large amount of sugar. If, then, the alcohol has a greater elective affinity for oxygen, there will be a tendency for the sugar to be stored as fat. The fattening of animals by a mixture of flour and spirits can also be explained on this principle; and, though the argument seems far-fetched, yet perhaps it is a pretty case in point that luminosity in urine is specially noticed in those of intemperate habits; and as such it would appear to be due to the presence of unoxidised phosphorous one may perhaps say that the appropriation of oxygen by the alcohol is a cause of a larger amount of unoxidised phosphorous in this secretion than is normal. Dr. Parkes thinks there is some probability of acetic acid being formed, from the fact of his having noticed an excess of acidity of urine after ingestion of alcohol. He does not think this acidity to be due to acetic acid, but is of opinion that acetic acid is formed in the blood, and combines with some of the alkali, and that this is elimimated by the urine as a carbonate. Of course this would cause acidity of urine by altering the relative amount of alkali to acid. MM. Lallemand, Duroy, and Perrin found that when aldehyde was introduced into the circulation of a dog, that acetic was discoverable within two hours in the blood. This observation is perhaps suggestive. Though the opinion seems well founded that alcohol does undergo oxidation, it is by no means certain that its combustion is complete, or what are the products of the decomposition of

alcohol in the system. Some observers think aldehyde is the result others acetic acid, but these substances have never been found, although they have often heen diligently sought for. Dr. Richardson is now engaged in investigating this point, and from theoretical considerations he is inclined to think that aldehyde is the form to which alcohol is reduced.

Alcohol, then, in passing through the system, when taken in small amounts, undergoes a destruction of some sort. It will be important to consider what is the effect of this destruction upon the organism. We have seen that if we can reckon alcohol as a food at all, it cannot be regarded as a tissue-forming substance; and must be classed among those which by their decomposition administer to some of the vital functions, and heat formation is one of the most prominent examples. There are many discrepancies in the results as to the effects of alcohol on temperature in the human subject, but in animals the effect is uniform. The following are the observations of Dr. B. W. Richardson, and as he was occupied for three years in the investigation of this point, they are well worthy of attentive consideration. He finds that the first effect of ingestion of Alcohol is a rise of temperature; which corresponds to the period of excitement, with relaxation and injection of capillaries; and this in *birds* may be ·1 deg. F.; in mammals rarely more than ·5 F.; in man the rise may be ·5 deg. F.; and in the confirmed inebriate, 1 deg. 5 F. If the Alcohol be pushed, and excitement, and some muscular inability are produced the temperature begins to fall, and in birds they may reach from 1·5 deg. to 2 deg. below the point at which it was previous to the rise. In mammals 1 deg. In man not more than $\frac{3}{4}$ of a degree. If the effect of the Alcohol be continued towards the production of coma; the fall is greater, and in birds may be 5·5 deg. In mammals 3 deg.; and in man often from 2·5 deg. to 3 deg. Dr. Ringer has also made many observations upon this part, and he finds that Alcohol only reduces the temperature to an unimportant degree, if a usual quantity be taken, but after a poisonous dose the depression may reach 2 deg. or 3 deg. F. He also finds that in drunkards the temperature is not lowered even when enormous quantities of Alcohol are taken. M. Perrin also finds a dimunition of temperature. In the course of forty-eight observations made by Bouvier on rabbits, cats, dogs, and man, the temperature was always lowered, and in animals in which fever had been excited, by injecting putrescent matters into the circulation; the febrile condition was reduced, and kept down by large and continued doses of Alcohol. Beer containing 3·4 per cent. only lowered temperature to the extent of ·5 deg, c.; wine containing 8 to 17 per cent. but ·2 deg. c. Dr. Parkes' conclusions are the same as Dr. Richardson's with regard to the final effect upon animals; but says results upon man are not uniform. There is a difference as to whether the person operated upon had previously been an abstainer from Alcohol, or not. In one case he administered eight fluid ounces of absolute Alcohol per diem, and he found neither alteration of temperature nor change in quantity of urea. A man upon whom he was making observations had an attack of catarrh, and he found Alcohol had no effect in diminishing his temperature. Obernier examined the effect of wine in typhoid and hectic fever, and even when the effect was pushed to intoxication there was no fall, but a rise; and I would especially draw attention to this solitary observation of rise of temperature, for though no alteration might occur, this is the only instance in which I have found this effect to have been observed. In healthy temperate men, accustomed to the use of Alcohol, Ringer, Obernier, Binz and Bouvier have either found that there was no change of temperature, or a decrease, never an increase. Binz experimented on Dr. Bainzer and another, the temperature being measured in the rectum. In Dr. Bainzer no noticeable alteration in the normal course of temperature was produced by taking spirits containing 98 per cent. Alcohol in doses of $\frac{1}{2}$ oz. to $2\frac{1}{2}$ oz. In the second case there was a tendency to fall which was not marked in the first observation, but in the second and third the fall was ·4 deg. and ·3 deg., which occurred at a time when without Alcohol there would be a rise. I have found it difficult in the hospital reports to find any well marked instances of diminution of temperature from Alcohol, and this arises from the fact that Alcohol has not, at least in the cases I have been able to find, been administered with this object in view, but the following appear to me to support the preceding observations:—

"The patient, a broker's clerk, was admitted feeling ill and exhausted. He had, when he had money, been in the habit of drinking large quantities of gin. The patient appeared to be in a state of starvation, and weaknees. He was in the hospital from July 18th, to July 23rd; and his temperature for the last four days was as follows:—July 20th, 95 deg.; 21st, 96 deg.; 22nd, 97 deg.; 23rd, 96 deg. This low temperature was not caused by deficiency of diet; and he was described as leaving the hospital well. Cannot it be reasonably ascribed to the Alcohol?"

2. In a case of acute Alcoholic poisoning from brandy; admitted into John Ward (April 17th, 1871); it was noticed by the clerk that the tempsrature of the skin was below normal.

In two cases of enterica under Dr. Habershon, in Addison, I think I have been able to trace a fall after the use of brandy.

3. The first was admitted June 28th, 1871, and on July 8th, I find the temperature as follows:—July 8th, 100 deg.; 9th, 100·6 deg.; 10th, 102·7 deg., 11th, 102·5 deg. Brandy ℥vi. ordered. 12th, 100·0 deg. Brandy ℥iv. ordered; and on the 14th, 100 deg.

4. The other case was admitted September 1st, 1871, and the following were the observed temperatures:—September 3rd, a.m., 103·4 deg.; 3rd, p.m., 103·7 deg.; 4th, a.m., 101·8 deg.; 5th, a.m., 101·9 deg.; 5th, p.m., 102·4 deg.; ordered ℥viii. wine; and on the 6th, there was a reduction of temperature, a.m., 100·8 deg.; 6th., p.m., 101·4 deg.; 7th, a.m., 100·3 deg.; 7th, p.m., 98·6 deg.; and this last was the average temperature afterwards, and it never went higher than 99 deg.

5. The next case gives a negative result. The disease was typhoid; and the patient was admitted January 17th, 1873, into Philip Ward under Dr. Rees. Wine ℥iv. ordered. Temperature:—January 18th, a.m., 99·9 deg.; 18th, p.m., 99·1 deg.; 20th, a.m., 99·4 deg.; 20th, p.m., 99·4 deg.; became much depressed, with no sleep and ℥iv. brandy were administered. Temperature:—21st, a.m., 99·3 deg.; 21st, p.m., 99 deg.

On the 22nd, ℥viii. brandy were ordered, and during the night ℥vi. were given. On the morning of the same day the temperature was 98·5 deg, and on the 23rd, 98·4 deg.; so that there was no diminution of temperature after ℥vi. of brandy.

(*To be continued.*)

Operations.

Friday, April 9.

The first operation was for necrosis of the frontal bone in a girl, æt. 19. A sinus led down to the diseased bone. Mr. Bryant made a vertical incision over sinus and found a piece of necrosed bone, the surface of which equalled that of a sixpenny piece: this, however, not being loose, was not removed.

Mr. Bryant next operated on a man, æt. 28, for necrosis of the metatarsal bone of right great toe. Three years ago a horse trampled on patient's right foot, which swelled up; but swelling soon subsided, leaving the foot quite natural. Five months ago the foot swelled again, and about four months after commenced to discharge. There were three sinuses through which dead bone could be felt. An incision was made over the length of the metatarsal bone and sequestrum removed from its base; the entire bone was found to be a suppurating cavity.

On the same day Mr. Bryant operated in the ward for hare-lip.

Saturday, April 10.

Mr. Bryant performed ovariotomy, having made the usual incision through the abdominal wall, the tumour a monocystic one was tapped and the fluid drawn off. The cyst turned out easily there being no adhesions. The clamp was then applied to the pedicle and the tumour removed. The edges of the wound were then brought together by three deep sutures, also about the same number of superficial ones. The lower part of the wound was left open for drainage.

Tuesday, April 13.

A man, æt. 76, was brought into the theatre from whom Mr. Birkett had previously removed an epulis from lower jaw. The growth was first noticed five months ago, but had grown rapidly. At the beginning of January Mr. Birkett first operated, gouging it from the alveolar process, and at intervals after this smaller portions, continuing to sprout out, were cut off. The tumour then became pulsatile and continuing to increase in size a further operation became necessary. Mr. Birkett, therefore, made an incision along the right side of the body of the jaw three inches in length avoiding the facial artery. The tumour was thus exposed from the outside, and by means of a chisel and small saw, was removed with some of the surrounding bone. The mental nerve was seen coming out of the foramen and passing over the growth, but was not involved in it. The edges of the wound were brought together by a continuous suture, and the following day had united by adhesion. The growth proved to be a round-celled sarcoma.

Mr. Forster excised the left elbow-joint of a girl, who, a year ago, received a blow on the elbow. The pain was confined at first to the upper radio-ulnar articulation; but since admission the disease has spread to the rest of the joint. The synovial membrane was much diseased, the cartilage on the bones eroded, but the bone healthy. The arm was flexed at a right angle, and put on a splint, the wound being dressed with wet lint.

Mr. Durham amputated through the thigh at junction of middle and lower third on a girl, æt. 11, whose knee he had excised two months previously. Anterior and posterior skin and muscular flaps were made; the bone was soft and bled freely, the periosteum early peeling off.

EYE WARDS.

R. C., four months ago (November, 1874) was poked in the left eye by a finger, between the eye-brow and globe. The tissues around did not turn black, but they immediately swelled, and he says that the next day he could not see out of eye, on account of the great swelling; he was blistered, &c., and in about a week the swelling subsided a good deal, but not entirely.

Jan. 22nd.—There is partial ptosis and paralysis of the superior rectus muscle, and a tumour can be felt in the position of the lachrymal gland (? enlargement of lachrymal gland). ℞ pot. iod. gr. v., tinct. cinchon. m. xx., ex. aquae ℥ j. t.d.s.

April 1st.—There is a fluctuating swelling of the size of a walnut situated below the outer part of the upper margin of the *left orbit*, connected with the lachrymal gland? The eye-ball is displaced downwards but its movements are unimpaired. Vision = $\frac{20}{50}$.

Ophthalmoscope.—Retinal vein distended. The optic disc is hyperæmic; no pulsation can be felt and none detected with the ophthalmoscope.

April 5th.—The tumour was tapped to-day with a fine trocar and ℥ ii. of semi-transparent yellowish fluid mixed with blood, removed.

L. C. came to O. P. Room on 30th march last, with a growth at the inner angle of right orbit. He states that it has only been growing one month, it came first as a small pimple over the caruncle. There is now a somewhat nodulated growth involving the semilunar fold and caruncle, projecting between the lids and extending outwards to the margin of cornea. The edge of its growth towards the cornea is slightly concave; it is of firmish consistence, and there is some muco-purulent discharge from the surface. The lids can be easily closed over it. Vision is perfect.

Mr. Higgens decided on removing it as it was probably a round-celled sarcoma.

On April 5th, patient was put under chloroform, and Mr. Higgens removed the growth, stitching the conjuctiva over the raw surface. Under microscopic examination it proved to be a round-celled sarcoma.

London School of Medicine for Women.—A new school for the medical education of women is advertised under the above title. The summer session will commence on Saturday, May 1st. Two entrance scholarships are offered, and candidates for these *must have passed a preliminary examination in Arts recognised by the examining Board.* The following compose the council:—Mrs. Garrett-Anderson, M.D., Dr. Charlton Bastian, Dr. Billing, Dr. Elizabeth Blackwell, Dr. Broadbent, Dr. King Chambers, Dr. Cheadle, Dr. Lockhart Clarke, Mr. George Cowell, Mr. Crichett, Mr. Ernest Hart, Mr. Berkeley Hill, Professor Huxley, Dr. Hughlings Jackson, Dr. Murie, Mr. A. T. Norton, Dr. Payne, Mr. W. S. Playfair, Mr. Reeves, Mr. Rivington, Dr. Burdon Sanderson, Dr. Stokoe, Dr. Sturges. The names suggest a curious admixture of feminine strong-mindedness with scientific eccentricity.

General News.

Several cases of scarlatina have occurred lately in the wards. One in Stephen, and another in Mary, while in Naaman a patient, who was well under the influence of belladonna, has been infected, and has since died. Unfortunately, our senior House Physician, Mr. Paul, and Mr. J. J. Newman, Mr. Birkett's dresser, have also been laid aside with it. The former is convalescent. Mr. Newman's case is complicated by rheumatic fever, but he is progressing favourably.

Through Mr. Paul's illness, Mr. Fry is acting as senior and Mr. H. Clarke as both second and junior House Physician. A vacancy for a House Physician has occurred in consequence of Mr. Tyson's resignation. Applications must be sent in to the Treasurer by Tuesday next.

Mr. Lees having resigned his appointment as Sen. Res. Obst. on the 12th, Mr. Gibb is, for a short time, in residence as Sen. in Charity.

The Clinical Wards are at present under Dr. Pye-Smith's care.

Mr. H. Williams, House Surgeon, has lately amputated twice through the thigh, and once through the fore-arm.

Alterations are being made in Patience Ward, by which the inner end will be converted into an erysipelas ward, in imitation of Inner Samaritan.

The north wall of Mr. Towne's room, which has been gradually sinking, is now being re-built.

There is a case of morbus Addisonii in a boy in 15, Clinical.

The patient who was treated for compound dislocation of the thumb, in the Surgery, and was admitted into Cornelius Ward, has since died from pyæmia. There were some abscesses in the lobus quadratus of the liver.

There is a case of general paralysis of the insane in 50, Stephen Ward.

A patient in Stephen Ward, with rheumatic fever, is being treated with Propyllamine.

ROYAL COLLEGE OF SURGEONS.

The following paper was set at the recent Anatomical and Physiological Examination for the diploma of Member :—

1. Describe the coagulation of the Blood ; and state what is the constitution, physically and chemically, of the component parts into which it is resolved when coagulated.

2. Describe the distribution of the Pneumogastric Nerve in the thorax, and state what are its functions in regard to the thoracic viscera.

3. Describe the articulations of the Atlas, with the occipital bone and the axis ; and the ligaments communicating these bones.

4. Give the attachments and nervous supply of each of the muscles which flex and extend the Thumb.

5. Describe the course, relations, and anastomoses of the branches of the Facial Artery which arise below the inferior maxilla.

6. In making a longitudinal section of the Encephalon in the median line, enumerate the parts divided, in their order from above downwards.

The following Guy's men were successful ;—

April 8th—Messrs. W. Dunstan, J. Hammersley, E. C. Greene, W. Lane, J. Morgan.

April 9th—Messrs. G. Mackern, T. C. Nugent, J. Poland, J. Reader, G. A. Wright.

April 12th—Messrs. O. Bowen and R. S. Wainewright.

Seventeen students from this hospital presented themselves in the first April Examination and *all passed*.

The Wards.

The following Cases were admitted between April 9 and April 14

MEDICAL.

Philip—5—Vomiting—gangrene of scrotum 9—Enlargement of ascending aorta 12—Paraplegia 25—Acute rheumatism 27—Ditto 30—Lead colic 32—Erythema marginatum 33—Lardaceons disease—phthisis 35—Acute rheumatism 45—Aortic obstruction and regurgitation 47—Acute phthisis 48—Acute rheumatism 50—Acute rheumatism

Bright.—3—Acute rheumatism 20—Chorea 23—Hemiplegia 25—Wasting 26—Pertussis

Addison.—3—Acute rheumatism 4—Erythema marginatum and nodosum 5—Acute rheumatism—pericardial and pleuritic effusion 9—Pyrexia 18—Hysterical mania

John.—1—Cirrhosis—ascites 2—Lead colic 3—Epilepsy—alcoholic 5—Chronic laryngitis 8—Aneurism

Miriam.—18—Epilepsy 24—Pleuro-pneumonia

Stephen.—3—Locomotor ataxy 7—Neurosis 13—Albuminuria 21—Pleuro-pneumonia—pericarditis 24—Phthisis 25—Bronchitis 30—Bronchitis 31—Lumbago 34—Paraplegia 40—Pleuro-pneumonia 42—Morbus cordis

Addison.—27—Ulceration of stomach ? 31—Dyspepsia Cot—marasmus

Mary.—3—Morbus cordis—albuminuria 6—Phthisis 6—Arthritis 7—Chronic gastritis 15—Bronchitis

SURGICAL.

Dresser for the week, Mr. H. Bartlett.

Ex-Dresser, Mr. Burton.

Naaman.—2—Suppurating bursa under ligamentum patellæ 5—Recurrent malignant growth of sub-maxillary glands 8—Recurrent malignant growth of cervical glands 9—Abscess on outer side of thigh 15—Aneurism of superficial femoral 18—Caries of tibia

Dorcas.—7—Ruptured intestine—death 10—Abscess under pectoral muscles 13—Angular curvature of spine—psoas abscess 18—Periostitis of femur 19—Scald of back—death 19—Irreducible umbilical hernia

Cornelius—23—Fractured tibia

Samaritan—4—Syphilis 6—Condylomata—soft sores 7—Syphilis

Accident—4—Compound comminuted fracture of humerus 13—Pott's fracture 15—Crushed foot 17—Crushed leg 19—Scalp wound

Received.—The London Medical Record, The Sanitary Record

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Guy's Hospital Gazette.

A Student's Journal of Hospital News, Medicine, & Surgery.

VOL. V.—NO. 29. SATURDAY, APRIL 24, 1875, TWOPENCE

IN the Introductory of 1872, Dr. PYE-SMITH made use of the following words:—"Next year we mean to compass a Cimonian victory, and win all along the line." However good our intentions may have been the prediction has not yet come true; but our results have up to this been so good that we would fain hope we are on the way to its accomplishment this year. Our gallant Football team have done nobly for us, and we had occasion, last week, to comment upon the unprecedented success at the First College. Let our University men look to themselves that they may not be found wanting. If our Honour List is to be good it is now that it must be made so—by steady, honest, plodding work; for it is not in the actual examination that scholarships are gained, This year we trust we shall have no men going up without Physiology for the First M.B. We believe it is a mistake of the University to allow it; at all events it is for the men to take advantage of it. It would be far better to put off the examination until the next time, for we have more than once seen the folly of the practice. The Cricket season has now commenced, and the hospital club is once more being started for the season. We believe it is weighted by a heavy debt; let Guyite *esprit de corps* not allow this, but let the hands of the club be strengthened, so that our arms may be successful in this direction. Soon we shall have to compete with other hospitals for the challenge shield, we trust we shall see it back again at Guy's this year; it will be a fit accompaniment to the beautiful foot-ball cup, and we hope our athletes, now that the trouble of the First College is over, will look to it.

Have we been too universal in desiring success from Guy's men? We think not; for have we not one of the largest numbers of men to select from amongst the London schools? We have more than once insisted that we are far from advocating a distinct division of labour in the athletic and intellectual races, but we believe pre-eminence in both are only obtainable in those few exceptions that prove the rule. We believe that the ratio of success is an inverse one up to a certain limit, and that high honours at the London University are only compatible with a limited amount of athletic exercise. Yet we are far from laying an embargo upon manual exercise entirely; we know a man cannot maintain himself in health without it, and we are sure that never is a game of cricket, or a row on the river, so thoroughly enjoyed as when it is taken as a relaxation from steady hard work.

There is nothing so successful as success. We have begun the year well; let us complete it as well.

"'Tis not in mortals to command success,
But we'll do more—we'll deserve it."

A STUDENT'S NOTES OF

Lectures on Midwifery.

By J. BRAXTON HICKS, M.D., F.R.S.

Obstetric Physician to, and Lecturer on Midwifery at, the Hospital.

LECTURE XXII.

ABNORMAL STATES OF THE PELVIS.—We have thus con-

sidered the principle abnormalities belonging to the soft parts concerned in labour. We have next to pass in review those connected with the bony passage—the Pelvis. Hitherto with few exceptions it is the soft parts that yield before the descending fœtal head. Now in almost every case of obstacle it will be the fœtal head which must accommodate itself to the passage. The only exceptions are the coccyx, the symphysis pubis, and perhaps the sacro-iliac synchrondoses; and the general pelvis in rare cases in mollities ossium. The sacro-coccygeal joint yields naturally. The pubic symphysis in some patients markedly, in others very slightly, though perhaps a little in all, becomes more relaxed as the pregnant woman approaches full term; and probably during labour in very marked cases; the total increase which might be added to the circumference of the brim, under the pressure of the head might be from $\frac{1}{8}$ to $\frac{1}{4}$ inch. The sacro-iliac joints also very slightly yield.

In mollities ossium in the flexible bone variety some yielding takes place; but only a change of form, a better adaptation of the pelvis to the shape of the head. How much may be allowed for this can hardly be stated. It would only be worth consideration in those cases where the want of relationship between the two was of the slighter kind.

But you must consider that the difficulties in labour from the pelvis may be only relative; in order words, your patient may have a pelvis within the average range of normality and the head may be also, and yet if both of them took opposite ends of the range there may be sufficient obstacle to make a very difficult labour. Again, if the head be small but within the average, and the pelvis large and yet within the average, the relationship may be very faulty, as faulty as we find with very large pelvis, and average sized head.

Hence it follows that for successful labour in any race, the fœtal head must correlate with the pelvis. Supposing we were bred, as animals are, to certain "points." Supposing large heads were the desire of the "fancy." Unless the pelvis correspondingly increased it would be impossible; either the children must die or the mother. However, no doubt, there is some sort of relationship between pelvis and head belonging as they do to the vertebral system. Nations vary much in type of head as of pelvis, and these are correlated sufficiently.

Now many of the abnormalities of the pelvis are due to want of development, either from the puerile state or from the masculine type. Some are due to distortions arising from different varieties of softening of bone at different epochs of life. These we shall discuss as we come to them.

We divide the abnormal forms of the pelvis into—

1. *Too large*, but well-proportioned: or, as it used to be called, œquibiliter justo major.
2. *Too small*, but well-proportioned: œquibiliter justo minor.
3. *Masculine* or funnel-shaped.
4. *Puerile*, or girlish.
5. *Ricketty*: softening before puberty.
   a—Ovate.
   b—Reniform.
6. *Mollieties ossium*, or adult softening crumpled: cordate, V-shaped, cocked-hat varieties.
7. *Oblique-ovate* of Nægelè: early ankylosis of one sacro-iliac joint.
8. Double early ankylosis of same kind.
9. Spondylolisthesis: or slipping of last lumbar vertebra forwards.

It is well that you clearly understand these, because when you have to contend with a difficulty the work is half accomplished before you begin to operate, if you clearly comprehend the nature of the obstacle. Blind pulling is always useless, often very mischievous, and a confession of ignorance. Let your motto be the well-known one, *Arte non vi*. Why should you try to drag through two inches of brim a solid body like the fœtal head of inches three and a half at least diameter. For, in any case, how much can you expect an unopened head to yield with a chance of preserving its life? Say the bi-parietal is four-and-a-quarter to four-and-a-half. What will any pressure of the forceps reduce it to? Say, at the outside, three-and-three-qnarters to four—or half an inch. Say, also, that you are trying to draw it through a pelvis of three inches and-a-quarter. What are you attempting to do? Namely, to drag a thing half an inch wide through a pin-hole. When will you succeed? Or rather when will you give it up? Not until you are tired and worn out? Not till the mother's soft parts included between the head and pelvic prominences are dead or torn, and the scalp of the child in the same condition? Think, then, before you begin. Do not attempt the impossible; but if you have so far either misjudged the obstacle, or having thought possibly the head was more yielding, you will try before proceeding to destroy life, then do not indefinitely continue your attempt, which has been legitimate; but, again, as accurately as you can, guage your difficulties. Why should you do, as I once knew a practitioner do, namely, give secale in a case of extreme pelvic distortion where craniotomy was necessary before, and premature labour had been urged for the next pregnancy, whereby the uterus was ruptured? Common reflection, with common sense, surely will save you from such calamities. There is nothing mysterious in midwifery, specially in dystocia from pelvic abnormalities: it is very mechanical, the treatment is definite. For instance, if the obstacle exceed the diameter of the fœtal head at its fullest reduction, it is plain that no traction alone will get over the trouble. However, between certain points at certain stages there are elements of uncertainty; but the range of these uncertainties are ascertainable with tolerable nearness. Let us now consider the abnormal states of the pelvis *seriatim*—

1. *Too large*, but all parts proportionately so.

What are its disadvantages? If the fœtal head about to pass through it was proportionately large, the labour would be natural. But supposing the head were average sized, what then? What law did I tell you existed in respect to labour pains? That, with limits, the greater the obstacle the greater the reflex irritation, and thus the stronger the pains. The converse holds true, the less resistance to the exit of the child, the less the reflex irritation, and the weaker the pains, and the longer interval between them. So that you see you may have a long, lingering labour, where the pelvis is larger than usual. But very often the uterus, instead of being well up above the brim, is already resting on the floor of the pelvis, and the os uteri close to the vulva. You are pleased at such an evidence of an early release and perhaps tell the patient it will shortly be over. Don't be so quick in assumptions. A few more labours of the kind will undeceive you. You will very likely have to wait a long time. The pains would reach their proper strength: they are short, the interval long; though even the advance is fair when the pains do come. But when it is over don't be in a hurry to be off. The uterus is not readily felt like the cricket-ball, and

when now and then it contracts there is a gush of more blood than you care to see, with a slight oozing between. Stop by the patient; do not leave for an hour or two; do not even put on a bandage, and go downstairs; either yourself or the nurse should keep the hand on the uterus holding it firmly, with an occasional friction over it. Whenever you find the child's head descends readily, short pains and long intervals, you not only have a capacious pelvis, but also a very relaxed state of soft parts; reflex irritation is at the minimum, and consequently even if the child escape there is not sufficient residue to keep the uterus contracted sufficiently to expel the placenta, and thus if detachment of a portion have occurred through the labour, hæmorrhage before delivery of placenta occur, and you are liable, if you follow the proper practice of removing the placenta, to find the uterus still atonic, uncontracting, and this at this juncture means, as I have frequently told you, hæmorrhage. Be provided for such an event; *mentally*, I mean, for I have already told you in all cases of midwifery have your arrangements perfect. As the child is descending give a dose of secale, rather retard the descent; don't be in a hurry to use the forceps; don't use them at all till uterine stimulants have failed, and then chiefly to induce action by the head's pressure. However, patience will do much. It is equivalent to a breech case in an average sized pelvis, where I have told you to expect lingering and ill-developed labour.

Besides these there is sometimes danger of a ruptured perinæum in a large pelvis, for if the head descend, as is sometimes the case, with strong pains, it comes on the perinæum rather than the coccyx; and the vulva not yielding readily it has to bear all the force and is ruptured. Again, after the patient is convalescent, the uterus, having but little support from the pelvis, is apt to descend on to the floor of it, and even pass externally; in other words, to be partially or even completely prolapsed.

NOTES ON HISTOLOGY.

(From Dr. Pye-Smith's Demonstrations of Practical Physiology.)

(Continued from page 220.)

Having now completed a survey of the elementary *tissues* of the body, there remains to examine the more important *organs*. These are all composed of various kinds of cells, of different forms of connective tissue, of striated or unstriated muscle and of nerve fibres.

Blood-vessels.—These vary so much in different parts that it is difficult to describe their general characters. The smallest *capillaries* consist only of a tube of hyaline, structureless membrane, lined by thin, flat, transparent epithelium (endothelium), each cell of which has an oval nucleus. This tube may be compared with the sarcolemma of a muscular fibre or the neurelemma (in the modern sense) of a nerve-fibre. The nuclei are readily seen by help of acetic acid or by staining with carmine, the endothelium is only demonstrated by staining with nitrate of silver. (A successful injection of the vessels of a guinea pig, killed by bleeding, with half per cent. solution, or direct staining of a frog's mesentery, shows them). The structureless "basement membrane," on which the endothelial cells rest, is very difficult to demonstrate apart from them; indeed its existence is not absolutely certain.

The smallest *arterioles* have outside the tubes just described a little delicate connective tissue, and also some spindle-shaped fibre-cells with their characteristic oblong nuclei. These are arranged transversely to the axis of the vessels, whereas the oval nuclei of the endothelium lie longitudinally. In larger arterioles these muscle-cells are so closely packed as to unite and form a continuous layer of unstriped fibres which run transversely round the vessel. Next is observed outside this layer some ordinary white areolar tissue. Thus we have three coats, the inner endothelial layer (*tunica intima*), the middle contractile muscular layer (*tunica media*), and the outer or fibrous coat (*tunica adventitia* sive *externa*).

Taking next an *artery* as big, say as the ophthalmic, we find that the connective tissue outside the endothelium contains yellow as well as white fibres, and in somewhat larger ones, as the radial, there is a distinct network of these, forming what is called the membrane fenestrata lying between the intima and the middle coat. The latter is also much thicker, consisting of several layers of muscle, longitudinal as well as transverse, with more or less white connective tissue. Lastly, the adventitia is also increased in thickness and like the other two coats, contains elastic as well as white fibres. In it runs the vasa vasorum.

The *aorta* and its primary branches have the thickest external coat, and contain most elastic tissue, but the muscular tunic is comparatively weak and the endothelium of the intima is often not demonstrable.

The *veins* consist of the same tissues as the arteries; but here the coats are much thinner, especially the middle and external ones. Muscular fibres are few or absent, the fibrous tissue is not so thick, and in many parts the intima is thrown into folds which form the valves of veins. In the vena cava there are muscular fibres in the *outer* coat, and usually their scanty presence in the media is compensated by increase of elastic tissue in this layer.

The easiest way to get a good view of blood-vessels is to take a piece of pia mater with brain substance adherent. Wash it in water and spread out a small fragment. The small arteries will be seen, with their external coat forming a lymphatic sheath around the media: this is a peculiarity of the vessels of the brain, cord, and retina. The middle coat will be recognised by its transverse rod-shaped nuclei; and the intima by its oval nuclei. These, of course, come out better with acetic acid or carmine staining. The smallest branches which run from the pia mater into the brain gradually loose their middle and outer coats and become capillary. To see capillaries well, however, nitrate of silver must be used as above described. The coats of an artery like the radial are best seen in transverse section, by squeezing it between two pieces of carrot or cork; or, better, by filling it with melted paraffin and oil (two parts to one) after getting rid of water by soaking it in alcohol. For larger arteries, strip off layer after layer, and spread each out as thin as possible, adding acetic acid. You will find the outer part of the external tunic consists chiefly of white, the deeper chiefly of elastic fibres: then come more elastic and some muscular fibres; and then the fenestratod layer of the intima. The valves of veins (*e.g.*, the saphena) show the endothelium of the inner tunic well, when stained with silver. Moreover, very instructive views of blood-vessels are gained when examining sections of many organs, especially the kidney, ovary, and liver. To see their arrangement and abundance in any organ it must be injected and mounted in strong

glycerine without previous staining, so as to make the tissue as transparent as possible. You cannot expect to see blood-vessels and tissues in the same preparation. This is for transmitted light. Opaque injections are of course mounted with a black ground, and must be seen with low powers and illumination with a bull's eye; the tissue is often corroded away to show the vessels better. For details see Dr. Beale's book, "How to work with the Microscope." Lastly, you should all be familiar with the appearance of the circulation in the web of a frog's foot, and with that of the vessels of the choroid and retina as seen with the ophthalmoscope.

ALCOHOL, A DRUG, FOOD, OR POISON.

By R. E. Carrington.

Being the Prize Essay of the Physical Society.

(Continued)

6. The following were the observations of the effects of wine in a case of phthisis, in which there was a high temperature, admitted into 16, Bright, on Nov. 7th, 1874, under Dr. Moxon. There was six months' history, and she was treated as follows on the 14th of that month:—Middle diet, milk, cod-liver oil, port wine ℥ iij. Nov. 16—Hot and feverish. Temperature—Nov. 16—a.m., 102·2; p.m., 100·4. Nov. 17—a.m., 102·2; p.m., 102. Nov. 18—a.m., 102·8; p.m., 102·8. Nov. 19—a.m., 104·4; p.m., 103·7. Nov. 20—a.m., 101·8; p.m., 102·6. Nov. 21—a.m., 102·0; p.m., 100·6. Nov. 22—a.m., 100·5; p.m., 100·4. The temperature was much the same up to the 27th, when ℥ x. port wine were ordered. On the 28th the temperature was 102·6, and on Dec. 1 103·2, Patient says she feels cooler, and thinks the wine is doing her good. Temperature—Dec. 2, 100·4; 3rd, 100·5; 5th, 99; 11th, 100; 18th, 98·3. Here the temperature for three days still continues high, but on the fourth day diminished, and never again reached so high as before. ℥ x. of port wine is by no means an excessive quantity, and therefore no sudden result could be expected; the subsequent depression of temperature is fairly attributed to the accumulation of alcohol in the system, because, as I am told by the clinical clerk, the phthisis got steadily worse, and therefore the cause of the high temperature persisted.

7. The following case of enterica was admitted into 12, Philip Ward, under Dr. Moxon, on Oct. 28, 1874. On the evening of the 28th the man's temperature was 104·6, pulse 136, ℞ brandy ℥ vi. On the 29th and 30th the brandy was by mistake omitted, and the man became very ill. Oct. 29, temperature, a.m., 104; p.m., 105. Oct. 30, 12.25 a.m., 104, pulse 108; 4.45 p.m., 103·4, pulse 110; 9 p.m., 103·4, pulse 112, restless, groaning, and starting. Did not answer questions for some time, and then his replies were wrong. On the 31st the brandy was administered. Temperature—Oct. 31, a.m., 103, pulse 108; p.m., 103·2, pulse 108. Nov. 1, a.m. 100·6, p.m. 102·4; he was now sensible. Nov. 2—he was ordered ℥ x. brandy; temperature, a.m., 99; p.m., 98·7, quiet. Nov. 3, a.m., 97·2; 9.30 p.m., 99·7; 11.30 p.m., 98. Nov. 4—a.m., 98; p.m., 97·6, not so deaf. Nov. 5—a.m., 97·6, bright and notices everything; p.m., 100·3. Nov. 6—a.m., 99, pulse 64, brandy ℥ vi.; p.m., 97, pulse 68. Nov. 7—a.m., 97·7, pulse 64. Nov. 8—a.m., 98, pulse 64. Nov. 9—a.m., 98·4, pulse 62. Nov. 10—a.m., 98, pulse 72. He steadily progressed to convalescence, and was out of bed on the 22nd. The objection unfortunately arises in these cases, that the fall of temperature is not due to alcohol, but rather to cessation of disease; but I think, as the fall of temperature is noticed in the majority directly after the administration of the alcoholic drinks, that we have some right in attributing it partly, at all events, to this cause.

8. The following case is possibly very open to this objection, but here the fall was immediate upon the administration of brandy:—Typhus, admitted Jan. 20, 1875, into Addison (Nos. 3 and 19), under Dr. Habershon. Temperature—Jan. 21st—a.m. 103·2, p.m. 105; 22nd, a.m. 103·6, wine ℥ vi., p.m. 104·2; 23rd, a.m. 103·3, p.m. 104·4; 24th, 104·8, p.m. 105·3; 25th, a.m. 104·6, brandy ℥ ij., p.m. 104·2; 26th, a.m. 102·6, p.m. 102·8; 27th, a.m. 101·8, p.m. 103·8, 28th, a.m. 101·5, p.m. 103·2; 29th, a.m. 101·4, p.m. 102; 30th, a.m. 100, p.m. 1·004, brandy ℥ vi., very ill; 31st, a.m. 98, p.m. 99·2; Feb. 1st, a.m. 98·4, p.m. 99·6; 2nd, a.m. 98·2. The temperature never arose above this average, and the patient is now convalescent.

I have made some observations of my own relative to this point, as I wanted to find whether the dietetic use of beer had any effect on temperature, with the following results—

Case No. 1. Male, æt. 23. Average morning temperature of seven days, after 35 days' total abstinence, 97·18; average evening temperature, do. do., 97·62; average morning temperature for seven days, after one week with mean of ℥ ij beer per day, 97·05; average evening temperature, do. do., 97·72. With beer.—average morning temperature, 0·13 lower; average evening temperature, 0·10 higher.

Case No. 2. Male, æt. 19. Average morning temperature of seven days of four weeks' total abstinence, 98·13; average evening temperature, do. do., 98·4. With beer.—average morning temperature (mean of one pint and a half beer per day) for seven days, 98·6; average evening temperature, do. do., 98·05; with beer, average morning temperature, 0·39 lower; average evening temperature, 0·35 lower.

Case No. 3. Female. Average morning temperature, last seven days of thirty days' total abstinence, 97·51; average evening temperature, do. do., 97·92; average morning temperature, last three days, 97·13; average evening temperature, do. do., 97·93. With beer—average morning temperature, three days, 97·26; average evening temperature, do. do., 97·53. Result—morning temperature, without beer, 0·25 higher; evening temperature, without beer, 0·4 higher.

It will be seen that in case No. 2 there is a slight fall of temperature after the use of beer.

In case No. 1 there is a fall in the morning temperature and a rise in the evening, after beer.

In case No. 3 there is a fall in the temperature (morning) and a rise in the evening temperature.

I think, then, there is no other possible conclusion than this, as to the result of alcohol on temperature:—that in health its action is to lower, and though there may be variations in the different results, that the effect, if there is any, is always a reduction.

The effect of alcohol on the elimination of carbonic acid would seem to vary somewhat as to the nature of the dose. Dr. Edward Smith is the most prominent in observations on this point, and his results are published in the proceedings of the Royal Society, 1859. With regard to the action of ardent spirits, he finds that they differ *inter se*, and that

some increase and others decrease the amount of carbonic acid expired; but he finds that this was the influence exercised by all of them was rather of a disturbing character, and that there was not that "regular progression of increase and decrease" observed as in ordinary foods. I will give a few of his observations.

1. ℥ j. of alcohol (75 per cent.) in ℥ vi. of cold water, average increase of expired CO_2 in grs. per minute, 0·18 and 0·8 on two occasions; quantity of air expired, 47 and 53; increase, 26 cubic inches.

2. ℥ ½ of same spirit, with cold water ℥ ij., every fifteen minutes for three hours; average increased expired CO_2, in grs. per minute, 0·74; increase of air expired, 37 cubic inches—the whole direct effect lost in 70 minutes.

A. Rum. 1½oz. of Navy rum (58 per cent. alcohol); increase CO_2, in grs. per minute (average), 0·26. and a minimum increase of 0·78, and 0·7 per minute.

B. ℥ ij. of very fine old rum (69 per cent.) maximum increase CO_2, in two persons, 0·1 and 1·5.

(*To be continued.*)

Operations.

Friday, April 16.

The next operation was simply exploratory. The patient, a man, æt. 26, had received a blow on the left loin; an abscess formed in the left groin, which was opened some time back. A probe could be passed along a sinus, leading from the floor of the abscess to a point posterior to the anterior superior spine of ilium; dead bone was suspected, though not felt. Mr. Bryant, having introduced into the sinus a probe, cut down upon its point; a quantity of pus was evacuated, but there was no evidence of necrosed bone; a drainage tube was then introducod into the opening, and the part dressed with oiled lint.

The next was the case of a man who had sustained, some months back, a compound comminuted fracture of the right leg. Some necrosed pieces of bone had been removed on a previous occasion. There were several sinuses through which exposed bone could be felt, but on cutting down on the part Mr. Bryant was unable to find any dead bone.

In the ward, and without chloroform, Mr. Bryant divided subcutaneously the tendons of the tibialis anticus and the extensor longus digitorum in a case of acquired talipes calcaneus.

Monday, April 19.

Mr. Bryant operated on a child, aged 14 months, for hare-lip, this being the second time of operating, the first having failed. Both sides of the lip were raised from the alveolus, their edges pared, and brought together by sutures, which were passed deeply, so as to be just under the mucous lining of the lip. The cheeks were well drawn forwards, and strapping applied ffom ear to ear; bleeding vessels were twisted.

Tuesday, April 20.

Mr. Birkett removed the breast of a woman, æt. 45, for carcinoma. It had been growing for twelve months, but had only slightly affected the axillary glands. The operation was done in the usual manner, and nothing of special interest was observed.

A girl was next brought into the theatre, æt. 23, suffering from a very large suppurating hydatid of the liver. It had been tapped four years ago, but latterly had grown considerably in size, impeding respiration, and causing great distress. Mr. Birkett, therefore, proceeded to perform paracentesis. The cyst was punctured in the middle line by a trochar, and about 80oz. of fluid evacuated by means of the aspirator. It was purulent in character and contained great numbers of small cysts characteristic of hydatids. A small pad was then placed over the puncture and pressure applied. Although it was feared that some extravasation might afterwards take place into the peritoneum, no symptoms of peritonitis have since appeared, and the patient's condition has been greatly improved by the operation. No hooklets could be discovered by microscopic examination of the contents of the tumour.

Wednesday, April 21.

Mr. Durham performed ovariotomy on a woman, unmarried, æt. 19 The tumour was first observed twelve months ago, since which time it has bsen steadily increasing. Menstruation regular before the tumour appeared, afterwards every six weeks. On admission, on the left side is a smooth, moderately hard, non-fluctuating mass, extending 8in. above umbilicus; on the right side is a cyst connected with the mass on the left side, and the sound passed the normal distance. The patient being under ether, an incision 4in. long midway between umbilicus and the pubes was made. The tumour immediately came into view, with a portion of the omentum adherent; the trocar and canula were passed into the fluctuating part of the tumour, and a pint of fluid drawn off. The omentum was then ligatured and divided and dropped back. The tumour was then turned round, and another cyst, which was situated at the back of the tumour, tapped, when about the same quantity of fluid was drawn out. The tumour was slightly adherent to posterior wall of abdomen; it was separated, and the tumour then came out. The pedicle was short, and was secured by a steel clamp and the edges of the wound brought together. The patient is doing well.

We have been unable to obtain reports of Messrs. Durham and Howse's operations this week, but hope to record them next.

EYE WARDS.

1. Senile cataract. Linear incision, then iridectomy upwards, and extraction.

2. Corneal opacity. Tinted.

3. Corneal opacity, with closed pupil. Good perception of light. Iridectomy downwards and outwards.

4. Traumatic cataract. The patient, a boy, was stabbed in the eye with a pen-knife, which perforated the cornea, causing some prolapse of the iris. The cataract was removed by suction.

5. A severe case of ectropion in both eyes, the right being the worst, was the one next operated upon. Mr. Higgens separated the upper lid from its adhesions, pared the margins of both sides, and united them with sutures.

6. This patient was operated upon for cataract on Nov. 16, 1874. The operation was followed by iritis, and the

pupil became blocked by opaque capsule; so to-day a portion of it was torn away by the needle.

7. This was a case of chronic glaucoma, affecting the right eye only, and iridectomy upwards was done. Mr. Higgens said that in performing iridectomy to influence the tension of the eyeball you should be careful to make your incision so as to enter the anterior chamber at its peripheral part, as you want to take away the whole width of the iris and not merely the pupillary portion.

8. Trichiasis, caused by granular ophthalmia. In this case part of the row of eye-lashes near the outer canthus were misdirected. The bulbs of these, with the corresponding portion of skin, were removed. In doing this operation be careful not to remove any of the tarsal cartilage, otherwise the lid may become narrowed and incapable of being closed entirely over the eye-ball.

9. Extirpation of right eye. The eye-ball was staphylomatous, in which condition it has been for fifteen years. No perception of light, and of late has been painful. The sound eye is threatened with sympathetic ophthalmia.

10. Convergent strabismus. As is usual in such cases, the patient was the subject of hypermetropia. The two eyes squinted alternately. Internal rectus divided in the left eye only.

11. Paralysis of the third nerve. A portion of the skin and orbicularis muscle was removed from the right upper eyelid, in order to form a cicatrix so as to draw the lid above the pupil.

Report of a Case.

M. A., æt. 37, married, was admitted into Dorcas Ward on the 20th inst., at 2 a.m., in a state of collapse, dying two hours afterwards.

Patient's history showed that she had been suffering for seven days from strangulated hernia, and that she had been treated with croton oil, &c. The hernia had been reduced at 11 p.m. of the previous day.

Post-mortem.—Abdomen distended and full of fœculent matter, intestines intensely injected. In the ileum, about 5ft. from the ilio-cœcal valve, was a knuckle of intestine 2½in. by 1½in. (not quite the whole of its calibre) almost gangrenous. At the line of constriction there was an opening ¾in. long, whose edges were covered with lymph. The sac of the hernia in the crural canal was ecchymosed, and the constriction scarcely admitted the tip of the little finger. The peritonitis was recent, apparently subsequent to the extravasation. The croton oil appeared not to have caused any congestion of the mucous membrane of the alimentary canal.

We are indebted to Mr. Burton for the above.

Received.—The London Medical Record, The Sanitary Record. Also a communication from "Studens."

General News.

There have been no more cases of scarletina in the wards.

Mr. Ferrier is now on duty as Junior Obstetric Resident.

Mr. Arthur H. Jones has been appointed House Physician, *vice* Mr. Tyson, resigned.

The Summer Session will begin on May 1st, on which day the lectures will be commenced.

In the male Clinical Ward are some good cases of aortic disease, two being definite cases of aneurism.

In Dr. Moxon's Wards are two cases of sclerosis—3, Philip and 9, Bright—and two cases of locomotor ataxy, 1 and 9, Philip.

There are at present two well-marked cases of Addison's disease in the wards—15, Clinical, a boy aged 14, and 13, Bright, a girl aged 17.

The following gentlemen passed the recent examination for the Licentiate of the Royal College of Physicians:—Messrs. Brown, H. Evans, and Johnston.

It is an interesting fact that our House Surgeons were both born upon the same day, but the junior, it is believed, was in advance of the senior by a few hours.

We are happy to report that Mr. Paul has now fully recovered from his recent attack of scarletina. Mr. Newman is also progressing favourably, but owing to complications his progress is not so rapid.

Dr. Braxton Hicks purposes to take abnormal labour only during the ensuing course of Midwifery lectures, and intends to make it as practical as possible. The first two days in each week he will devote to oral instruction, the last two to practising the class in operations. Although the course will be open to men of all years, the practical portion will include third and fourth years' men only.

The following gentlemen were admitted to the Membership of the Royal College of Surgeons on the 20th:—Mr. John Rees, L.R.C.P. Ed: On the 21st—Messrs. Hobson, L.R.C.P., Rawlings, L.S.A., Romano, L.S.A., and Waterhouse. Messrs. Judson and Leigh passed in Surgery. On the 22nd—Messrs. Bond and Lockwood. Mr. Kellard passed in Surgery. Nine presented themselves for examination, and *all passed.*

The wards of the Hospital have been well supplied with flowers of late. Many of these have been picked by country children, and sent to London. Some cultivated flowers are also added, and the whole distributed by the London Flower Mission, which is now striving with great success to increase the cultivation of flowers among the poor of the City. The distribution of these flowers in the London Hospitals is of quite recent introduction.

Answers to Correspondents.—"Studens" must please send his name and address before we can insert his communication. We trust all our correspondents will note this, as it would save much delay and trouble were the true name always communicated as well as the *nom de plume.*

The Surgery.

On Wednesday, the 14th, a man came to the Surgery, having received a blow from the hook of a crane while it was being drawn up after being relaxed from its burden. It struck the right eye-lid, which it lacerated and also separated a layer of bone from the supra-orbital ridge. The piece of bone was about ½in. square, and seemed to be detached from all the surrounding tissues, except the periosteum. By the blow it had also been turned round at a right angle to the frontal bone, forming a swelling above the eye, while a probe introduced into the laceration in the eyelid impinged on a surface of bare bone. By means of a probe thus introduced and external digital manipulation, the fragment was restored to its original position. The wound was syringed out with carbolic acid and gauze applied. The wound has since healed, and the fragment seems to have become united to the surrounding bone. The eye-ball was not injured, although ecchymosis appeared all round the orbit.

The Wards.

The following Cases were admitted between April 15 and April 21

MEDICAL.

Philip—5—Acute tonsilitis 12—Paraplegia 17—Bronchitis and emphysema 18—Bronchitis 27—Acute rheumatism—pericarditis 30—Lead colic 89—Kyphosis—ascites—paracentesis abdominis 32 Acute rheumatism—diastolic aortic

Bright—1—To and fro aortic 5—Diabetes 7—Phthisis 23—Hemiplegia

Addison—4—Erythema marginatum and nodosum 16—Pyrexia 18—Hysterical mania

Miriam—28—Malignant disease of liver 25—Tubercular meningitis

John—2—Lead colic 2—Lead paralysis 3—Broncho-pneumonia, death 3—Bronchitis—mitral regurgitation 4—Apoplexy, death 4—Pleuro-pneumonia—laryngeal spasm 7—Tubercular meningitis, death 7—Sub-acute rheumatism 9—Pleurisy

Mary—14—Dysmenorrhœa 17—Sub-acute rheumatism 22—Tympanites

Stephen—23—Diabetes 28—Right pleuritic effusion 33—Phthisis 43—Morbus cordis 43—Sub-acute rheumatism

SURGICAL.

Dresser for the week, Mr. A. de W. Baker

Ex-Dresser, Mr. H. Bartlett.

Guy's Hospital.—The Summer Session

commences on Saturday, May 1st.

MEDICAL OFFICERS.

Consulting Physicians—Sir W. W. Gull, Bart., M.D, D.C.L, F.R.S; G. Owen Rees, M.D, F.R.S
Physicians—S. O. Habershon, M.D; S. Wilks, M.D, F.R.S; F. W. Pavy, M.D, F.R.S; W. Moxon, M.D
Assistant-Physicians—C. Hilton Fagge, M.D; P. H. Pye-Smith, M.D; F. Taylor, M.D
Consulting Surgeons—John Hilton, Esq, F.R.S; Edward Cock, Esq
Surgeons—John Birkett, Esq; Cooper Forster, Esq; Thomas Bryant, Esq; Arthur E. Durham, Esq.
Assistant-Surgeons—H. G. Howse, M.S; N. Davies-Colley, M.C
Consulting Obstetric Physician—Henry Oldham, M.D
Obstetric Physician—J. Braxton Hicks, M.D, F.R.S
Assistant Obstetric Physician—A. L. Galabin, M.D
Ophthalmic Surgeon—Charles Bader, Esq
Assistant Ophthalmic Surgeon—C. Higgens, Esq
Surgeon Dentist—J. Salter, M.B, F.R.S
Assistant Surgeon Dentist—H. Moon, Esq
Aural Surgeon—W. Laidlaw Purves, Esq
Medical Registrars—F. Taylor, M.D, and J. F. Goodhart, M.D
Surgical Registrar—Frederick Durham. Esq

The Hospital now contains 630 beds. Of these 220 are for Medical Cases; 250 for Surgical; 25 for Diseases of Women; 48 for Syphilitic and 50 for Ophthalmic cases. There are also 30 Children's cots, and 66 reserve beds (8 in private rooms).

In connection with the Lying-in Charity, about 2500 cases are annually attended by the Students.

Number of patients relieved during the year, about 81, 000.

LECTURES AND DEMONSTRATIONS.

Medical Jurisprudence—A. S. Taylor, M.D, F.R.S
Materia Medica—W. Moxon, M.D
Midwifery—J. Braxton Hicks, M.D, F.R.S
Ophthalmic Surgeon—C. Bader, Esq
Pathology—C. Hilton Fagge, M.D
Hygiene—F. Taylor, M.D
Comparative Anatomy—P. H. Pye-Smith, M.D
Morbid Histology—H. G. Howse, M.S
Botany—Paul Stokoe, M.D
Practical Chemistry—H. Debus, Ph.D, F.R.S
Natural Philosophy—A. W. Reinold, Esq
Operative Surgery—A. E. Durham, Esq
Cutaneous Diseases—F. Taylor, M.D
Dental Surgery—H. Moon, Esq
Mental Diseases—G. H. Savage, M.D
Practical Pharmacy—Instruction will be given in the Hospital Dispensary on payment of a small fee.

Clinical Lectures in Medicine, Surgery, and Diseases of Women, weekly, by the Assistant-Physicians, Assistant Surgeons, and Assistant Obstetric Physician.

Special Classes are held in the Hospital for Students preparing for the Examinations of the University of London, and of the College of Surgeons.

The Museum of Anatomy, Pathology, and Comparative Anatomy—Curator, C. Hilton Fagge, M.D.—contains 10,000 specimens, 4,000 drawings and diagrams, an unique collection of Anatomical Models, and a series of 600 Models of Skin Diseases.

Appointments.—The House-Surgeons and House-Physicians, the Obstetric Residents, Clinical Assistants, Dressers, Clinical Clerks, and Dressers in the Eye Wards, are selected from the Students according to merit.

Prizes.—Two Scholarships of the value of £60 and £30 are awarded in October to first year's Students for proficiency in Classics and Mathematics, Modern Languages, Botany, Physics and Chemistry.

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For further information, apply to the Dean. Dr. F. Taylor, or the Secretary, Mr. Stocker.

Guy's Hospital, April, 1875.

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